U.S. ARMY-BAYLOR UNIVERSITY

GRADUATE PROGRAM IN HEALTH CARE ADMINISTRATION

A STUDY TO COMPARE THE COST OF CONTINUING TO OFFER INPATIENT SERVICES AT DEWITT ARMY COMMUNITY HOSPITAL VERSUS PAYING CIVILIAN PROVIDERS FOR INPATIENT SERVICES AT THE PREVAILING CHAMPUS REIMBURSEMENT RATE

A GRADUATE MANAGEMENT PROJECT SUBMITTED TO THE FACULTY OF THE U.S. ARMY-BAYLOR UNIVERSITY PROGRAM IN PARTIAL FULFILLMENT OF REQUIREMENTS FOR THE DEGREE OF MASTERS OF HEALTH CARE ADMINISTRATION

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13. ABSTRACT *(Maximum 200 words)*

This Graduate Management Project compares the cost of continuing to offer inpatient services at DeWitt Army Community Hospital (DACH) versus paying civilian providers for providing these services at the prevailing CHAMPUS rate (a "make" or "buy" decision). A review of the costs to "make" and "buy" inpatient services at DACH is done using the same method as CAPT Lane T. Rogers (1994), with slight modifications adopted by CPT Michael D. Crandell (1996). Efforts to contract externally for inpatient services reimbursed at a discounted rate lower than the CHAMPUS prevailing rate have proven largely unsuccessful.

The goal of this study is to advise the DACH Governing Board on the financial implications of continuing to provide inpatient services in-house vice paying for local providers at the prevailing CHAMPUS rate. Fiscal year 1996 (FY96) inpatient data are used for the conduct of this study.

The results of this study show that inpatient services should remain at DACH. Even with the possibility of negotiating a discounted inpatient service contract with local civilian providers, DACH clearly provides inpatient services at a significantly lower cost.

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ABSTRACT

This graduate management project compares the cost of continuing to offer inpatient services at DeWitt Army Community Hospital (DACH) to paying civilian providers for providing these services at the prevailing Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) rate--a "make" or "buy" decision. A review of the costs to "make" and "buy" inpatient services at DACH uses the same method as used by CAPT Lane T. Rogers (1994) with slight modifications adopted by CPT Michael D. Crandell (1996). Efforts to contract externally for inpatient services reimbursed at a discounted rate lower than the CHAMPUS prevailing rate have proven largely unsuccessful.

The goal of this study is to advise the DACH Governing Board on the financial implications of continuing to provide inpatient services in house as opposed to paying for services from local providers at the prevailing CHAMPUS rate. Fiscal year 1996 (FY96) inpatient data is used for the conduct of this study. The final result of the "make" equation indicates the amount of federal appropriations required to provide DACH's FY96 inpatient workload in house:

Total MEPRS Inpatient Expense		$15,401,739
Total MEPRS Inpatient Expense	$15,401,739	
Less Inpatient Salary Savings	-$6,800,197	
Less Other MEPRS Savings	-$3,039,941	
Equals MEPRS Fixed Costs	$5,561,601	
Less MEPRS Fixed Costs		-$5,561,601
Equals: The Revised Federal Appropriation for DACH to Provide Inpatient Services in FY96		$9,840,138

The final "buy" equation cost for DACH's FY96 inpatient workload if provided outside of DACH by civilian providers is as follows:

Total CHAMPUS Allowable Charge (no discount)	$20,348,945
Plus CHAMPUS Professional Fees	+$6,864,500
Less Patient Cost-Share	-$10,112,254
Equals FY96 Total Cost to buy DACH's FY96 Inpatient Workload from local civilian providers	$17,101,191

The results of the study show that inpatient services should remain at DACH. Even with the possibility of negotiating for a discounted inpatient service contract with local civilian providers, DACH clearly provides inpatient services at a significantly lower cost.

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CHAPTER 1

INTRODUCTION

As the health care industry experiences numerous mergers, consolidations, reductions, and closures of facilities, one can only wonder what is in store for the present day survivors. Tenet Healthcare Corporation's purchase of Ordna Healthcorp for $1.82 billion is an example of the mega-mergers recently occurring in the industry (Rundle 1996). This merger created a 126 hospital chain in a 22 state region and over $8.5 billion in revenue (Rundle 1996).

The financial survival of many health care facilities and networks is being affected by broad changes in the industry. Acquisitions and mergers of hospitals rose 44 percent between 1994 and 1995 (Hospital & Health Networks 20 APR 96). Hospitals now depend on utilization management and case managers in an effort to contain costs (Feldstein 1993). Kongstvedt asserts the health care industry has adopted numerous data collection systems on provider outcomes and productivity. Economic indicators on providers are created from the results of these data collection systems by health care managers (Kongstvedt 1995). This system of economic comparison of providers is known as "provider profiling."

Some facilities have used provider profiling to determine whom they will employ and to justify changes in daily operations. Other organizations use provider profiling to re-engineer themselves through the identification of less productive services for internal

process redesign. This has led many independent health care firms to embrace the once feared juggernaut known as managed care.

The Canadian health care system's adoption of managed care has led to ethical problems regarding resource allocation decisions (Meslin 1997). The United States (U.S.) health care industry has similar ethical problems concerning containment of costs and resource allocation. A statement by the chief of cardiothoracic surgery at a major U.S. university hospital reflects what many health plan enrollees believe is the major fault of managed care, "When managed-care companies look at things, I think quality is an issue, but the three most important things are cost, cost and cost" (Anders 1996).

The civilian health care sector is not the only one with its eye on cost. The military health services system (MHSS) has recently adopted a new program known as TRICARE. The commander of the local military hospital will be held strictly accountable for the health care of the hospital's enrolled DoD beneficiaries under this program. If TRICARE enrollees are not satisfied with the care the military medical treatment facility (MTF) provides, they may elect to enroll with the civilian TRICARE contractor when the option becomes available each year. The MTF commander does not want to lose his enrollees. The enrollees' switch from the MTF to the civilian contractor translates to a reduction in the commander's "capitated" budget.

The TRICARE contractor will receive funding equal to the historic CHAMPUS expenditures for those beneficiaries it enrolls. The contractor's for-profit motive has often led to a reduction of fees to practitioners and fewer patient contacts in order to increase profits (Willis 1996). DoD has closed many of the loopholes which existed in

some of the early TRICARE contracts. These loopholes had allowed the contractor increased profits for treating fewer patients and providing fewer benefits to those patients they do treat. DoD has kept abreast of the recent trends in the civilian health care industry. Mergers, consolidations, reductions, and closures of facilities are buzz words throughout the government as well as the military and military medicine.

DoD has undergone significant changes since the establishment of the Base Realignment and Closure Commission (BRAC). This Commission was created by the Defense Base Closure and Realignment Act of 1990 (P.L. 101-510, title XXIX, part A). It is a disinterested party charged with the identification of DoD facilities for closure or scaling back of operations. The existent Commission replaced the DoD's internal commission that was suspected of partisan recommendations. Of the four Commission recommendation lists to date, GAO report NSIAD-96-172 states that 311 bases and activities have been identified for closure with another 112 bases scheduled for realignment (GAO 1996).

In order for the MHSS to do its share of the military's downsizing and cost saving, it has conducted analyses of its operations. Two examples of these analyses are the *National Capital Area Study* (Vector Corporation 1995) and the *Small Hospital Survey* (facilities with 50 beds or less) (Vector Corporation 1992). These studies were conducted to identify possible services and sites for reduction or closure.

The results of the *National Capital Area Study* identified redundant services provided by multiple MTFs as candidates for consolidation. Statistically, the *Small Hospital Survey* demonstrated the need for one of the following actions for each facility:

(1) maintaining a facility as is; or (2) reducing it to a "super clinic"; or (3) closing the facility. The *Small Hospital Survey* employed utilization, availability of care from other sources, and cost as variables to arrive at its conclusions. Although the small hospital study recommended closure or reduction in services at various sites, the results were not supported by many of the affected districts' elected officials. As a result, major cost savings were not achieved. Few of the study's recommendations were adopted.

Cost was also the primary concern in the studies by Rogers and Crandell. These studies were conducted to inform the respective decision makers of the financial impact of their decisions on the provision of patient services. Both Rogers' and Crandell's studies concluded that it would cost less to purchase inpatient services from civilian providers.

Conditions Which Prompted the Study

DACH is known as a community-oriented, primary care facility. The major elements of a community-oriented primary care facility include: (1) the clinical practice of comprehensive primary medical care; (2) the use of applied epidemiology in practice planning; (3) the involvement of the community in program planning; (4) the use of data gathered in practice planning and organization; and (5) a continuing surveillance of community health status and needs (Kovner 1995). DACH also provides inpatient care to DoD beneficiaries in its catchment area.

DACH provides primary health care services and selected specialty care to 134,063 eligible DoD beneficiaries (DMIS FY96). These beneficiaries include: 12,569

active duty members; 111,010 non-active duty beneficiaries under 65 years old; and 10,484 Medicare eligible beneficiaries (Figure 1).

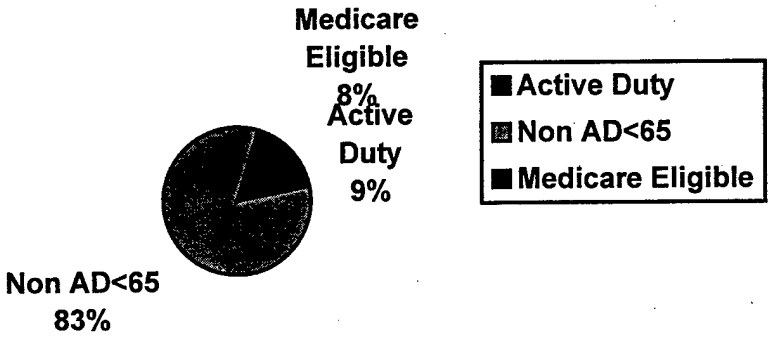

Figure 1. Beneficiary Categories. Source: DMIS FY96.

Figure 2 displays a by-service breakdown of the beneficiary population by sponsor's branch of service: 63,244 Army; 20,621 Navy; 24,310 Air Force; 22,606 Marine; and 3,642 Coast Guard or other.

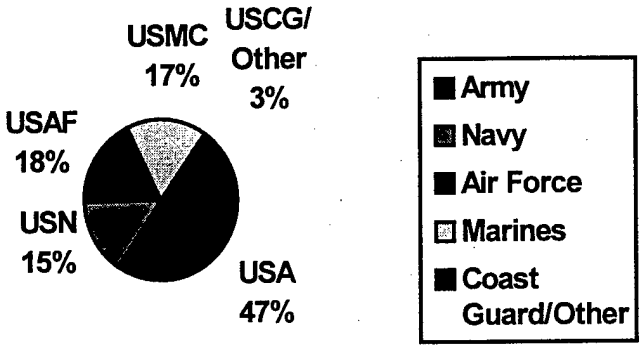

Figure 2. Beneficiary Sponsor's Branch of Service. Source: DMIS FY96.

The DeWitt Health Care System has four main portals of entry: (1) the forty-year-old main hospital which houses 63 staffed beds, limited specialty care, and the Family Health Center of Fort Belvoir; (2) the Family Health Center of Fairfax; (3) the Family Health Center of Woodbridge; and (4) the Family Health Center of Fort Myer. The family health centers are community (population) based to provide ambulatory care to their beneficiaries. Figure 3 is a graphical representation of the DeWitt Health Care System.

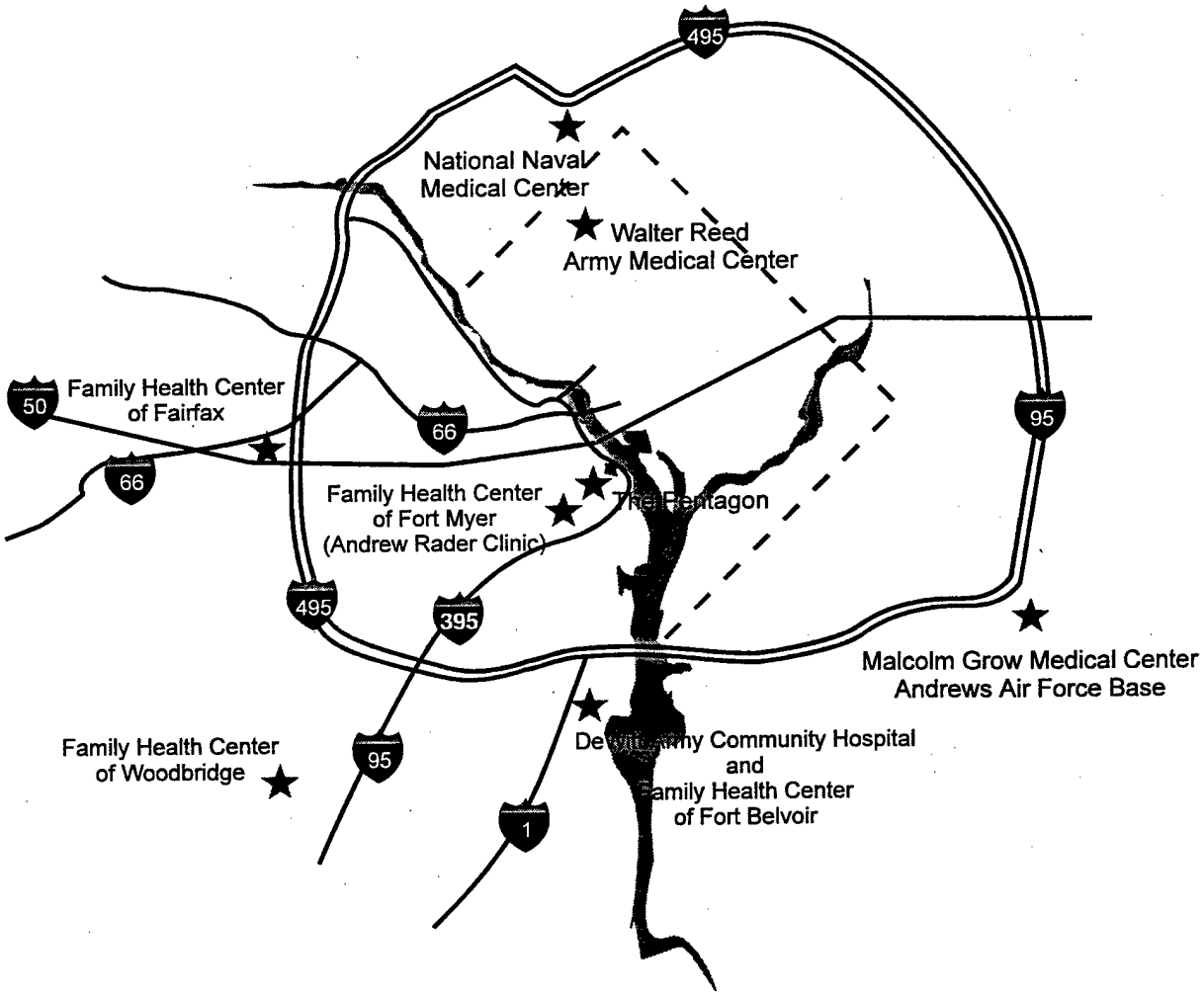

Figure 3. Map of DeWitt Health Care System. Source: Ms Susan Allen, Chief of Marketing, DeWitt Health Care System.

DACH has been directed to develop and implement a plan to reduce the fiscal year 1997 (FY97) budget by $5 million. This 11 percent reduction was part of the Army Medical Department's budget reduction plan. DACH's commander and Executive Committee must consider drastic measures to stay within this projected FY97 budget. Even without the budget decrement, the commander should remain keenly aware of the cost of health care provided at DACH.

DACH is at a key juncture as a health care organization. If DACH's inpatient costs exceed local civilian providers' costs, then very careful consideration should be given to adopting a "buy" position. Benefits of providing care, e.g. readiness concerns, would need to be weighed against the additional cost. If DACH is in the "buy" position, DACH will purchase inpatient services from other institutions. The decision maker must remember that if care is provided by civilian providers under the current CHAMPUS system, the Government pays for 75 to 80 percent of the patient's bill (OCHAMPUS 1994). Those CHAMPUS costs come straight from DACH's budget. If CHAMPUS costs go up, adequate measures must be taken to increase DACH's economic efficiency in providing care. If DACH is in the provider position, DACH should provide inpatient services up to its maximum capacity.

Statement of the Problem

The management problem is to compare DACH's FY96 inpatient costs to the cost of those same services provided by local civilian facilities reimbursed under CHAMPUS.

Review of the Literature

A review of the literature indicates there are a variety of financial trends in the health care industry. These trends include governmental interventions, cost containment measures, mergers, closures, resource sharing, staffing reductions, and termination of less profitable services. Many of the trends are attempts to improve provider, facility, or network financial situations.

Insights into an organization's profitability may be gained by comparing cost of providing services against other facilities providing similar services. Cost comparisons of this nature are on the rise (Sopariwala 1997). Most of these comparisons have studied capacity levels within networks or given facilities. Sopariwala states this is due to the fact that "inpatient care prices are market-driven and do not depend on the actual cost of delivering care" (Sopariwala 1997). This statement implies that purchasers of inpatient services should be able to buy services at fair market rates. DACH might opt to "buy" inpatient services if the CHAMPUS reimbursement rate is lower than DACH's cost to providing these services.

CHAMPUS costs are calculated using adjusted standard amounts published annually in the *Federal Register* (Escobar 1996). Adjusted standard amounts represent the average operating costs for the treatment of CHAMPUS beneficiaries during a selected time period, each fiscal year. The adjusted standard amounts are assigned to each diagnosis related group (DRG).

DACH's cost of providing inpatient services is reflected in the Medical Expense and Performance Reporting System (MEPRS). The MEPRS report (Appendix E)

provides financial and usage data for each inpatient service at DACH (MEDCOM 1996). Each service is assigned a MEPRS code (i.e., internal medicine's code is AAAA). The data related to each MEPRS code is listed in the columns to the right of the codes contained in the report. The final two columns display the average length of stay and average daily patient load. Page three of the MEPRS report states the formulae used to e calculate these figures, ALOS and ADPL (MEDCOM 1996). Average length of stay equals the number of occupied bed days divided by the number of dispositions during the period. Average daily patient load equals the number of occupied bed days divided by the number of days in the period.

MEPRS provides DoD with a mechanism to compare MTF health care costs with the costs of care under CHAMPUS and managed care support contracts (Escobar 1996). DoD decision makers have used MEPRS data to support decisions to create a DoD mail-order pharmacy system, to establish core budget funding for MTFs, to determine the appropriate size of MTFs, and to consolidate activities performing similar missions (MEDCOM 1996).

Mergers and consolidations of organizations are often undertaken to reduce layers of hierarchical positions within both entities and cut costs by giving more work to fewer workers (Robertson 1996). Resource sharing increases the likelihood of maximum return on investment by increasing utilization of the resource, while providing discounted rates to the outsider (Kassirer 1996). Reduction of an organization's staff provides immediate cost savings as salary and wage expenses go down relative to the number and type of

employees released. Lastly, the manager may decide to terminate the provision of a given service based on the organization's inability to compete with its competitors.

These financial trends relate little, or not at all, to the improvement of the patients' costs or outcomes. In *Bed Number Ten*, Sue Baier relates how simple efforts by hospital staff members can help a patient immeasurably (Baier 1985). Baier's book is based on her experiences as a long-term patient in an intensive care unit. Improvements in patient care can occur without causing any significant increase in costs (Baier 1985, 1996). Stories like Ms Baier's raise public concern over what the true focus of today's health care industry should be--patient care or cost control.

The government intervenes when health care providers or insurers display an apparent lack of focus on patient outcome or satisfaction. Governmental intervention in the health care industry occurs as legislation. For example, the State of Washington has granted antitrust clearance, on a case by case basis, for proposed hospital mergers in exchange for promises of price increase limits (Burda 1996). Governmental activities have helped and hurt the patients, providers, and hospitals (Burda 1996). Authors have reported both financial successes and failures as a result of mergers, consolidations, and legislation.

Another example of governmental intervention in health care is the recent maternity stay legislation in 31 states (West 1996). President Clinton used his office to endorse efforts to require health insurance plans to provide coverage for 48-hour minimum hospital stays following normal vaginal deliveries (West 1996). Clinton

praised the Blue Cross and Blue Shield Plan of Pennsylvania for voluntarily adopting the minimum coverage.

Managerial personnel in many health care networks perceived state legislation dictating minimum lengths of stay as an imposition on the caregiver's judgment. These network mangers saw this as the first step in a possible governmental plan to dictate minimum lengths of stay for all categories of patients. Pam Drellow, spokesperson for the Blue Cross and Blue Shield Plan of Pennsylvania, stated, "We're pleased at the President's comments, but we remain opposed to federal regulations on length of stay" (West 1996).

Frustrated and irate health care providers have attempted to influence governmental actions pertaining to length of stay. Some providers have informed their representatives that network utilization managers have criticized certain physicians for inappropriate lengths of stay and for the use of expensive non-generic drugs (Fine 1996). Both of these indicators are then scrutinized to compare individual providers with one another and entire networks against their rivals. Fine states the roots of these indicators can be traced to a 1983 cost containment initiative--the introduction of DRG reimbursement (Fine 1996).

Efforts at cost containment are evinced by the shift from inpatient care to ambulatory care, mergers for vertical and horizontal integration (Lagnado 1996), and reductions in staff and facilities (Robertson and Dowd 1996), as well as the embracing of utilization review (Kongstvedt 1993). Utilization review efforts have led to programs that identify hospital admissions that are inappropriate and lengths of stay that exceed

established guidelines (Kongstvedt 1993). Many health care executives are convinced that a well-run health care organization can survive only if it monitors and keeps in check physicians' performances (Gradison 1996).

Health care within the United States Army Medical Department is influenced by utilization review and cost containment strategies. The BRAC was formed to plan the military's biggest cost containment strategy--the identification of units and installations for termination or scaling back of operations (Palmer 1993).

DoD has felt the need for downsizing as budgets have continued on a downward slope the last few years (Dervarics 1996). The DoD Health Affairs response to re-engineering initiatives was the creation of a program known as TRICARE. TRICARE is the DoD managed health care program. TRICARE was introduced to facilitate a capitation-based, resource allocation health care system for the military. It provides for the enrollment of DoD health care beneficiaries to the MTF where they will receive their primary care (Martin 1994). TRICARE is scheduled to start in the northeastern U.S., DACH's region, in April 1998.

A major similarity between TRICARE and health maintenance organizations (HMOs) is that both require enrollment. Enrollment data provide the health care provider a key benefit. The provider for an enrolled population will know the number and type of patients he serves by age group and gender. These statistics are used with local usage factors to calculate the likely demand for primary and specialty care appointments.

Even with increased accuracy in predicting enrollee usage, some managed care organizations have sold off their HMOs. This is due to the dichotomous pressures of

providing patient service and the financial expectations of owners (Kertesz 1996). These networks employed the cost containment strategy of downsizing. The health care industry was not the first to embrace the downsizing trend as a cost containment strategy. However, the health care industry has been a large participant in the last few years (MacPherson 1996).

Managed care has forced many U.S. hospitals and individual providers to re-evaluate their role in the provision of health care (Rogers 1994). Many doctors have left their specialties and have reverted to primary care (Oliver 1996). HMOs have continued to compete for market share through mergers and acquisitions (Hospital & Health Networks 20 March 1996, Stahl 1995). Two major payers, large industrial employers and the government, have exerted pressure on health care organizations. These major payers have not seen adequate changes in the health care industry to meet their expectations of reduced costs (Moore 1996, Gardner 1995).

Recent cost studies on the financial feasibility of military hospitals have considered the "make" or "buy" option of various inpatient services. Rogers conducted a cost comparison study of Wilford Hall Medical Center. Rogers' study compared Wilford Hall's FY93 inpatient costs as shown in MEPRS, with the CHAMPUS cost reimbursement for the same workload (Rogers 1994). A study by Watkins (1995) explored the differential costs of providing an individual inpatient service, cardiothoracic surgery, at Wilford Hall Medical Center based on Rogers' methods (Rogers 1994).

Crandell's study compared the FY95 inpatient workload "make" costs at Bliss Army Community Hospital to the CHAMPUS "buy" cost of those services using a slight

modification to Rogers' methodology (Crandell 1996). Crandell's 1996 work used Rogers' formulae to advise the command on a make or buy decision for all inpatient services at Bliss Army Community Hospital (Crandell 1996). McNeill's 1994 study on determining the costs of graduate medical education within the military gave the Army Medical Department a method for putting a dollar amount to what had previously been an intangible cost (McNeill 1994). Martin's 1994 work attempted to determine the most cost efficient staffing model for a military primary care setting. Martin's study resulted in the adoption of a new primary care oriented staffing model by many military treatment facilities (Martin 1994).

Rogers' and Crandell's studies both concluded the civilian sector was the better financial choice--less expensive. The results of their studies indicated that local civilian health care providers, being reimbursed at CHAMPUS rates, could provide inpatient services for DoD beneficiaries at lower rates than could the respective military facilities. However, neither facility has closed its inpatient service to date.

Military readiness and continuum of care considerations are the likely justifications for these decisions. Each organization must clearly identify its vision and values. These guiding precepts should be reflected in all strategic decision outcomes (Duncan, Ginter, and Swayne 1995). The military will always have a need for hospitals in the future. However, the number and configuration of these facilities and the number of active duty military providers within those facilities may change drastically. This graduate management project, based on the cost methodologies of Rogers, will assist the facility by providing timely information using tried methods.

Purpose of the Study

The purpose of this study is to compare the cost of providing inpatient services at DACH to the cost of purchasing inpatient services from civilian providers reimbursed at the CHAMPUS rate--a "make" or "buy" decision. The alternate hypothesis is that inpatient services provided at DACH cost less than would the same services if they were provided by civilian providers reimbursed at CHAMPUS rates. The null hypothesis is that inpatient services provided at DACH do not cost less than would the same services if they were provided by civilian providers reimbursed at CHAMPUS rates.

CHAPTER 2

METHODS AND PROCEDURES

The primary data source for this study, as with Rogers' and Crandell's earlier works, is the MEPRS data base. The shortcomings of using the MEPRS data base as cited by Rogers are still applicable to this study. MEPRS fails to capture all costs directly attributable to the facility. These costs include facility depreciation, automation support, and medical readiness (Rogers 1994).

This study's methods include a review of the costs to "make" or to "buy" inpatient services for DACH. The formulae used throughout this study were used by Rogers and Crandell (Rogers 1994, Crandell 1996). Rogers received guidance for the formulae development and use from the national CHAMPUS office (OCHAMPUS), located in Aurora, Colorado (Rogers 1994).

"Make" Equation

The "make" equation utilizes MEPRS data to calculate the government's cost of providing inpatient services at DACH. The goal of analyzing MEPRS data is to determine the relevant costs of providing inpatient services (Rogers 1994). Relevant costs are those costs incurred that are directly related to each case of inpatient care provided. Direct and indirect costs plus a predetermined percentage for department level costs are calculated to allocate costs to the inpatient service (Watkins 1995).

The MEPRS report (Appendix E) provides the initial "make" equation costs for inpatient services. An adjustment must be made to the amount reflected on the MEPRS report. The amount of fixed costs assigned to the inpatient services must be reallocated among the other hospital services. This fixed cost component is determined by subtracting the estimated inpatient salary component (Appendix D) and other direct and indirect cost components (Appendix G) attributable to the inpatient services from the initial MEPRS inpatient cost (Crandell 1996).

The MEDCOM Manpower Assessment Model version 1.0 is used to identify the positions on DACH's 0196 TDA that should be eliminated if DACH provided only outpatient services. Consultation with DACH's department and section chiefs confirmed which paragraph and line number positions should be deleted if inpatient services did not exist at DACH. The calculation of the inpatient salary component requires identifying military and civilian positions to be eliminated.

The military inpatient salary component is determined by using rates from the FY96 Army Composite Standard Rates Table (DFAS-IN-AM 201507Z AUG 95). This table includes costs for "quarters, subsistence, medical, and personnel support" in addition to base salary figures (DFAS-IN-AM 201507Z AUG 95). The civilian inpatient salary component is determined by using calendar year 1996 federal pay tables for the specific position code of each worker. The step four level (wage grade) and step five level (all others) are used as median figures to facilitate the inpatient salary computation. The civilian workers' annual income figures also include a five percent increase for

retirement plans. This is to account for the government's maximum matching contribution for enrollees in the Thrift Savings Plan.

The other MEPRS cost savings (Appendix G) reflects reductions or eliminations of costs supporting inpatient care. These cost savings include reductions in the cost of linen procurement and laundering, the cost of food stuffs for the inpatient tray service, and the cost of food-service equipment support. Another cost saving is the termination of 5.67 full-time equivalent Certified Registered Nurse Anesthetists positions--a saving of $617,200.

Subtracting the inpatient personnel salary savings and the other MEPRS costs savings from the total MEPRS inpatient expense yields the MEPRS fixed cost component. The "fixed cost component" is defined as that part of the total operational costs of DACH which remains if inpatient services are eliminated at DACH. The fixed cost component consists of items such as: (1) administrative staff salaries apportioned through the step-down process to inpatient services; (2) costs related to the physical plant of the facility--depreciation, maintenance, housekeeping, and utilities; and (3) costs of contracts for services and equipment such as transcriptionists' fees and pharmacy drug counting machines.

Fixed costs assigned through MEPRS for DACH's inpatient services are calculated using Formula 4, Appendix F. DACH's MEPRS assigned fixed cost for inpatient services is determined by subtracting the sum of the inpatient salary savings and the other MEPRS savings from the total MEPRS inpatient expense.

DACH's revised funding level is calculated using Formula 5, Appendix F. The revised Federal appropriation is determined by subtracting direct inpatient costs from the total MEPRS inpatient expense. The result of Formula 5, Appendix F, is the basis for DACH's "make decision".

"Buy" Equation

This study follows Rogers' "buy" equation rather than Crandell's modification of it. DACH still provides obstetrical and gynecological inpatient services--these costs are included in the calculation of inpatient costs. Crandell omitted all obstetrical and gynecological inpatient services from his study because his facility no longer provides these services.

The "buy" equation (Formula 3, Appendix F) is used to calculate the total CHAMPUS costs for DACH's FY96 inpatient workload. This formula includes an estimation of the professional fees for DACH's inpatient workload to ensure an accurate calculation of all CHAMPUS costs. The cost of the professional fees is estimated by using Rogers' formula and DACH's actual CHAMPUS expenses reflected on the *CHAMPUS Health Care Summary by Diagnosis* (Appendix B) for FY96.

The estimated cost of professional fees is calculated using Formula 1, Appendix F. The total government hospital cost (Appendix E) is divided by total government professional fees cost (Appendix E) to yield the professional fee multiplier. The total hospital CHAMPUS charge for DACH (Appendix C) is then multiplied by the professional fee multiplier to yield the estimated cost for CHAMPUS professional fees.

Patients in most cases are responsible for paying part of the total hospital bill. This is the "patient cost-share." The amount of the cost-share usually ranges from 20 to 25 percent of the total allowable CHAMPUS charge. The total estimated patient cost-share is calculated by using Formula 2, Appendix F. The total patient cost-share is divided by the total number of inpatient admissions to yield the average cost-share per admission. The average cost-share per admission is multiplied by the number of inpatient admissions at DACH (Appendix C) to yield the total estimated patient cost-share.

The total cost to "buy" DACH's inpatient services is calculated by using Formula 3, Appendix F. The total allowable CHAMPUS charges (Appendix C) are added to the estimated cost for CHAMPUS professional fees. From this sum, the patient cost-share is subtracted to yield the total CHAMPUS cost to "buy" DACH's inpatient services. Comparison of DACH's revised Federal funding level with the total CHAMPUS cost to "buy" inpatient services shows whether it is more expensive for DACH to "make" or "buy" inpatient services.

The reliability and validity of this study depend on the accuracy of the MEPRS data reviewed (Rogers 1994). MEPRS is the accepted DoD Health Affairs standard for data accuracy in military health care (Rogers 1994). The CHAMPUS data base is accepted by the Health Care Financing Administration and is used to estimate future costs of the CHAMPUS program (Escobar 1996).

The amount of error in a measured process determines the reliability of the study. DACH's entire FY96 inpatient workload is the sample population of this study. This sample population was designed to reduce the potential of seasonal skewing of the

inpatient workload. Confidentiality of patient information was protected during the conduct of this study to ensure the privacy of patient data.

CHAPTER 3

FINDINGS AND UTILITY OF RESULTS

This graduate management project is designed using the formulae used by Rogers (1994). The cost of DACH's FY96 inpatient workload (Appendix E) is compared to the CHAMPUS reimbursement civilian providers would have received if they had provided services equivalent to DACH's FY96 inpatient workload.

This study provides a comparison of DACH's FY96 inpatient MEPRS costs in comparison with the costs of purchasing the same services from civilian providers reimbursed by CHAMPUS. The findings of this study will be relevant to decision makers in determining the level of inpatient services for DACH as part of the FY98 budget planning process. This study does not prove that the number of inpatient episodes of care will remain constant for DACH once TRICARE operations start. TRICARE operations will have an impact on patient usage and provider requirements.

The results of this study, using FY96 data, are of concern to the DACH command group even without knowing the actual effects of TRICARE--a possible decrease in the quantity of inpatient services demanded due to increased patient costs. The current DACH patient population possessing third party insurance is also expected to change due to the onset of TRICARE. These patients are more attractive to DACH to enroll in TRICARE. DACH would receive funding for these patients based not only on the

captitated rate for enrollees, but also gain the benefit of additional funds through the third party collection program.

DACH should continue to examine costs and concentrate scarce financial resources on the most cost efficient means of providing care to beneficiaries. The outcome of this study indicates there is no financial need for closure of DACH's inpatient services. While DACH is not in competition with the civilian hospitals, DACH could be downsized or closed if the civilian sector is perceived as less expensive. The economic viability of DACH requires the command to be an efficient provider of health care.

DACH's continued pursuit of more efficient methods of follows contemporary strategic planning principles (Duncan, Ginter and Swayne 1995). DACH must take action now to influence what services it will offer in the future. Cost comparisons such as this study must be done to evaluate each of DACH's services. "Make" or "buy" decisions made now can provide potentially vast savings. DoD is conducting "make" versus "buy" studies in many areas to determine whether to contract out for various services. These studies are a necessity as DoD attempts to do more with less (GAO/T-AIMD-95-146 1995).

CHAPTER 4

DISCUSSION

Numerous articles have reported the possible savings the government could realize if many of its functions were provided by civilian firms. The government has been exploring these options for more than a decade. The cost of health care provided within DoD was compared with CHAMPUS costs in a 1985 DoD report. The report concluded that the MHSS enjoyed a 44 percent cost advantage over the civilian sector in the mid-1980s (Rogers 1994).

In recent years though, there has been a huge push for the privatization of governmental functions. Newer studies have been conducted to compare the MHSS to the civilian sector. A 1994 DoD report states the cost to provide care by the MHSS is no longer significantly less than the civilian sector. The cost advantage was reported to have "dropped to a 1 to 2 percent margin" in favor of the MHSS (DoD 1994).

The results of this study are significantly different from those of Rogers (1994) and Crandell (1996). The results of Rogers' and Crandell's studies demonstrated their respective facilities were not cost competitive with the civilian sector (Rogers 1994, Crandell 1996). DACH, however, is shown to have provided care at a much lower rate than potential CHAMPUS providers.

Cost efficiencies developed in recent years by the command at DACH, may have influenced the outcome of this study. Also, the high cost of professional services in the

Washington D.C. area may have significantly effected the outcome of this study. The professional services provided by the civilian sector are estimated to cost 50 percent more those provided by DACH. The results of this study warrant further investigation on possibly a regional basis to see if any of the other federal MTFs in the area demonstrate similar findings.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

The results of this study indicate DACH is a less expensive provider of inpatient services than the civilian sector reimbursed by CHAMPUS--$9,840,138 compared to $17,101,191. This outcome supports the alternate hypothesis of the study. DACH's provision of inpatient services should continue if this decision is based solely on a cost comparison.

The National Capital Area's high cost of living may have led area health care providers to have abnormally higher costs when compared to DACH. The steps DACH has taken steps to reduce cost inefficiencies in its provision of care. DACH's decision to provide a community-based delivery system with a focus on primary care and wellness is justified in Shortell's writings (1996). Some of DACH's significant cost advantage indicated by this study may be attributed to the adoption of the principles employed in managed care.

The results of this study are significantly different than the studies conducted at Wilford Hall (Rogers 1994) and Bliss Army Community Hospital (Crandell 1996). DACH's managed care workload concentrates heavily on primary care. Wilford Hall Medical Center provides a high volume of specialty care as well as graduate medical education. Bliss Army Community Hospital provides a low volume of general medical care. DACH's concentration on primary care is a cost containment strategy in

preparation for TRICARE. This study shows that the continuation of inpatient services at DACH is a prudent financial decision in support of its primary care mission.

This conclusion should be explored further in other studies to evaluate the cost efficiencies derived specifically from the employment of managed care principles. Further use of the MEDCOM Manpower Assessment Survey Model version 1.0 is not recommended. The model's successor, the Automated Staffing Assessment Model (ASAM), is currently being fielded by the U.S. Army MEDCOM Strength Management Division. ASAM is scheduled for full deployment by 1 January 1998 (Esparza 1997). ASAM was designed as a refinement of its predecessor. It will facilitate MTF command decisions on TDA positions based on workload to provider modeling.

Future studies should account for the impact of the third party collection program. The third party collection program is a recent change to MTF financial calculations. The program allows MTFs to bill third party insurers for a portion of health care provided to DoD beneficiaries who possess civilian health insurance. FY96 was DACH's first full year to participate in the third party collection program. DACH provided MEDCOM with $1,158,383 in FY96 (Mack 1997).

In FY96, MTFs were required to give all income generated through the third party collection program to MEDCOM. In FY97 and thereafter, MEDCOM will establish a third party collection program goal for each MTF. This goal will be in the form of a decrement from the MTF's core budget. Income from the third party collection program received above the established decrement is kept by the MTF and added into the MTF's budget (Mack 1997). This provides the MTF with an incentive to garner as much income from the third party collections program as possible.

DACH is projected to add $600,000 in third party collection program funds to its FY97 budget. This amount is in excess of DACH's program goal, budget decrement, of $755,000 (Mack 1997). This addition makes DACH's already favorable cost comparison look even better. The program was not factored into this study, as the funds generated through the program during FY96 all went to MEDCOM.

DACH also is now remunerated by other governmental agencies from which it could not previously collect. The cost of health care provided by DACH to members of the United States Coast Guard, the National Oceanic and Atmospheric Administration, and the United States Public Health Service is now reimbursable. This addition to DACH's coffers constitutes an additional improvement in DACH's comparison to CHAMPUS paid providers.

Upon examination of the results of this study, only one cost comparison conclusion can be reached: care at DACH is much less costly than that delivered by civilian providers reimbursed at CHAMPUS rates. This conclusion supports the premise that DACH should remain a provider of at least some, if not all, of the inpatient services it currently provides. Some economies of scale may be derived by a consolidation of certain services with other NCA MTFs, but further cost analysis studies should be conducted prior to any decisions along these lines.

APPENDIX A

List of Acronyms

ASAM - Automated Staffing Assessment Model

BRAC - Base Realignment and Closure Commission

CHAMPUS - Civilian Health and Medical Program of the Uniformed Services

DACH - DeWitt Army Community Hospital

DRG - diagnosis related group

DoD - Department of Defense

FY - fiscal year

HMO - health maintenance organization

MEPRS - Medical Expense and Performance Reporting System

MHSS - military health services system

MTF - medical treatment facility

NCA - National Capital Area

APPENDIX B

DACH FY96 Healthcare Summary by Primary Diagnosis

REPORT SPECIFICATIONS PAGE

THIS REPORT SUMMARIZES COST AND UTILIZATION DATA. INPATIENT AND OUTPATIENT DATA ARE PROVIDED FOR 26 MEDICAL SPECIALTIES, WITH GRAND TOTALS. THIS REPORT IS BASED ON BENEFICIARY RESIDENCE ZIP CODES. FOR CATCHMENT AREA REPORTS, THE MILITARY HEALTH SERVICES SYSTEM CATCHMENT AREA DIRECTORY IN EFFECT DURING THE REPORT PERIOD IS USED TO DETERMINE THE CATCHMENT AREAS.

THIS REPORT EXCLUDES CHAMPVA DATA, CONTRACTOR DENIED CLAIMS, AND CLAIMS WITH ZERO GOVERNMENT OR CONTRACTOR COST. FOREIGN COUNTRY CLAIMS ARE INCLUDED. BILLED CHARGES FOR DENIED LINE ITEMS ARE INCLUDED, BUT THE NUMBER OF SERVICES IS NOT.

THIS REPORT REFLECTS CARE PROVIDED UNDER CHAMPUS IN A FLOATING 12-MONTH PERIOD. THE DATA COLLECTION PERIOD IS 15-MONTHS. SEE THE "USER'S GUIDE FOR THE CHAMPUS WORKLOAD REPORTS" FOR ESTIMATED COMPLETION RATES.

THIS REPORT CONTAINS STANDARD CHAMPUS, CHAMPUS REFORM INITIATIVE (CRI), AND MENTAL HEALTH DEMONSTRATION (NORFOLK, VA) DATA. PLEASE NOTE THAT DATA FOR BOTH PARTNERSHIP AND NON-PARTNERSHIP CLAIMS ARE INCLUDED IN THIS REPORT.

BEGINNING WITH THE APR 93 - MAR 94 REPORT PERIOD, SOME MEDICAL SPECIALTIES WERE RE-ALIGNED, ADDED, OR DELETED, I.E. "GROUPS I AND II PSYCHIATRY" WERE RE-GROUPED UNDER "MENTAL HEALTH." "DRUGS" WERE ADDED AS A SPECIALTY TO REFLECT COST AND UTILIZATION FOR OUTPATIENT PRESCRIPTION DRUGS. ALSO BEGINNING WITH THIS REPORT PERIOD, THE AVERAGE COST PER OUTPATIENT VISIT FOR "GRAND TOTAL ALL CATEGORIES" WILL INCREASE SIGNIFICANTLY, BECAUSE OUTPATIENT DRUG COSTS ARE NOW INCLUDED IN THIS TOTAL. THE NUMBER OF NON-VISIT SERVICES UNDER "DRUGS" IS THE NUMBER OF OUTPATIENT DRUG PRESCRIPTIONS FOR MORE DETAILED INFORMATION ABOUT THIS REPORT, REFER TO THE USER'S GUIDE.

OCHAMPUS/INFORMATION SYSTEMS DIVISION/STATISTICS BRANCH

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CHAMPUS HEALTH CARE SUMMARY BY PRIMARY DIAGNOSIS
BASED ON CARE RECEIVED FROM OCT 1995 THRU SEP 1996
123 - DEWITT AH FT BELVOIR, VA

********** CATEGORY OF CARE - INTERNAL MEDICINE **********

	ADVERSE REACTIONS	ALLERGY	CARDIOLOGY	DERM-ATOLOGY	ENDO-CRINOLOGY	GASTRO-ENTEROLOGY	HEMA-TOLOGY
I INPATIENT HOSPITAL SERVICES							
USER BENEFICIARIES	22	19	89	3	11	40	10
DEPNT OF ACT DUTY SPONSOR	13	14	21	2	5	14	3
RETIREE	1	1	48	1	2	8	2
DEPNT OF RET OR DEC SPONSOR	8	4	20	0	4	18	5
TOTAL HOSPITAL ADMISSIONS	22	21	113	4	12	45	10
HOSPITAL DAYS	34	58	566	29	39	164	102
AVERAGE LENGTH OF STAY (DAYS)	1.55	2.76	5.01	7.25	3.25	3.64	10.20
AVERAGE DAILY PATIENT LOAD	0.09	0.16	1.55	0.08	0.11	0.45	0.28
TOTAL GOVERNMENT COST	41,109	37,026	1,184,285	16,855	20,394	117,057	37,534
TOTAL PATIENT COST	7,068	11,779	161,209	75	25,886	55,189	13,724
TOTAL GOVT AND PATIENT COST	48,177	48,805	1,345,494	16,930	46,280	172,246	51,258
AVG GOVT COST PER ADMISSION	1,868.59	1,763.14	10,480.40	4,213.75	1,699.50	2,601.27	3,753.40
AVG GOVT COST PER DAY	1,209.09	638.38	2,092.38	581.21	522.92	713.76	367.98
II INPATIENT PROFESSIONAL SERVICES							
USER BENEFICIARIES	57	24	253	15	21	130	17
DEPNT OF ACT DUTY SPONSOR	25	15	46	8	7	50	5
RETIREE	9	2	132	1	6	33	7
DEPNT OF RET OR DEC SPONSOR	24	7	76	7	8	47	6
NUMBER OF VISITS	145	127	1,855	9	75	470	78
NUMBER OF NON-VISIT SERVICES	122	10	656	13	8	233	24
TOTAL GOVERNMENT COST	11,934	6,049	341,766	1,908	2,747	33,660	4,214
TOTAL PATIENT COST	6,353	3,582	233,940	291	2,545	23,198	3,642
TOTAL GOVT AND PATIENT COST	18,287	9,631	575,706	2,199	5,292	56,858	7,856

III TOTAL INPATIENT SERVICES							
USER BENEFICIARIES	67	32	264	17	22	141	22
DEPNT OF ACT DUTY SPONSOR	31	20	48	9	7	52	6
RETIREE	10	2	138	2	6	35	9
DEPNT OF RET OR DEC SPONSOR	27	10	79	7	9	54	8
TOTAL GOVERNMENT COST	53,043	43,076	1,526,051	18,763	23,141	150,716	41,748
TOTAL PATIENT COST	13,421	15,362	395,148	366	28,431	78,387	17,366
TOTAL GOVT AND PATIENT COST	66,464	58,438	1,921,199	19,129	51,572	229,103	59,114
AVG GOVT COST PER ADMISSION	2,411.05	2,051.24	13,504.88	4,690.75	1,928.42	3,349.24	4,174.80
AVG GOVT COST PER DAY	1,560.09	742.69	2,696.20	647.00	593.36	919.00	409.29
IV OUTPATIENT PROFESSIONAL SERVICES							
USER BENEFICIARIES	963	2,158	2,294	4,437	1,036	2,419	309
DEPNT OF ACT DUTY SPONSOR	549	1,293	539	2,636	348	1,277	131
RETIREE	83	161	821	472	227	302	53
DEPNT OF RET OR DEC SPONSOR	333	722	940	1,342	464	844	125
NUMBER OF VISITS	896	11,502	6,708	6,217	2,152	2,911	1,785
NUMBER OF NON-VISIT SERVICES	2,564	2,927	14,092	6,667	6,199	9,699	2,408
TOTAL GOVERNMENT COST	99,703	379,286	669,697	318,589	161,489	347,957	111,017
TOTAL PATIENT COST	72,016	216,075	534,852	162,845	129,566	278,005	79,004
TOTAL GOVT AND PATIENT COST	171,719	595,361	1,204,549	481,434	291,055	625,962	190,021
AVG GOVT COST PER VISIT	111.28	32.98	99.84	51.24	75.04	119.53	62.19
V OUTPATIENT CARE COST SHARED AS INPATIENT							
USER BENEFICIARIES	0	0	0	0	0	0	0
DEPNT OF ACT DUTY SPONSOR	0	0	0	0	0	0	0
RETIREE	0	0	0	0	0	0	0
DEPNT OF RET OR DEC SPONSOR	0	0	0	0	0	0	0
TOTAL GOVERNMENT COST	0	0	0	0	0	0	0
TOTAL PATIENT COST	0	0	0	0	0	0	0
TOTAL GOVT AND PATIENT COST	0	0	0	0	0	0	0

VI TOTAL INPATIENT AND OUTPATIENT CARE							
USER BENEFICIARIES	997	2,167	2,376	4,445	1,045	2,482	319
DEPNT OF ACT DUTY SPONSOR	563	1,297	559	2,639	350	1,305	134
RETIREE	88	161	859	473	230	317	57
DEPNT OF RET OR DEC SPONSOR	349	727	965	1,346	468	864	129
TOTAL GOVERNMENT COST	152,745	422,361	2,195,748	337,352	184,630	498,673	152,765
TOTAL PATIENT COST	85,437	231,436	930,001	163,211	157,996	356,391	96,370
TOTAL GOVT AND PATIENT COST	238,182	653,797	3,125,749	500,563	342,626	855,064	249,135

HR085-007 (OHRJ6Q) CHAMPUS HEALTH CARE SUMMARY BY PRIMARY DIAGNOSIS

********** CATEGORY OF CARE - INTERNAL MEDICINE **********

	INFECTIOUS DISEASE	NEPH-ROLOGY	NEU-ROLOGY	NUTRI-TIONAL	PULMONARY RESPIRATORY	RHEUMA-TOLOGY	OTHER
I INPATIENT HOSPITAL SERVICES							
USER BENEFICIARIES	14	7	34	1	84	16	261
DEPNT OF ACT DUTY SPONSOR	7	4	18	0	27	2	249
RETIREE	2	1	6	0	23	6	0
DEPNT OF RET OR DEC SPONSOR	5	2	10	1	34	8	12
TOTAL HOSPITAL ADMISSIONS	14	6	35	1	86	17	265
HOSPITAL DAYS	69	18	735	1	304	60	702
AVERAGE LENGTH OF STAY (DAYS)	4.93	3.00	21.00	1.00	3.53	3.53	2.65
AVERAGE DAILY PATIENT LOAD	0.19	0.05	2.01	0.00	0.83	0.16	1.92
TOTAL GOVERNMENT COST	55,514	15,456	296,572	114	267,242	133,613	500,637
TOTAL PATIENT COST	9,135	4,611	56,480	911	87,870	30,093	21,422
TOTAL GOVT AND PATIENT COST	64,649	20,067	353,052	1,025	355,112	163,706	522,059
AVG GOVT COST PER ADMISSION	3,965.29	2,576.00	8,473.49	114.00	3,107.47	7,859.59	1,889.20
AVG GOVT COST PER DAY	804.55	858.67	403.50	114.00	879.09	2,226.88	713.16
II INPATIENT PROFESSIONAL SERVICES							
USER BENEFICIARIES	39	37	107	11	305	41	318
DEPNT OF ACT DUTY SPONSOR	13	13	42	7	75	6	260
RETIREE	13	12	27	2	116	9	15
DEPNT OF RET OR DEC SPONSOR	13	12	38	2	116	26	48
NUMBER OF VISITS	204	129	512	121	1,406	44	693
NUMBER OF NON-VISIT SERVICES	55	29	162	14	454	92	217
TOTAL GOVERNMENT COST	13,056	10,076	39,934	11,155	88,770	35,613	65,220
TOTAL PATIENT COST	6,367	9,572	42,679	2,481	60,926	45,210	15,280
TOTAL GOVT AND PATIENT COST	19,423	19,648	82,613	13,636	149,696	80,823	80,500

III TOTAL INPATIENT SERVICES							
USER BENEFICIARIES	45	40	117	12	318	42	391
DEPNT OF ACT DUTY SPONSOR	18	14	48	7	79	6	336
RETIREE	13	12	28	2	117	10	15
DEPNT OF RET OR DEC SPONSOR	14	14	41	3	124	26	56
TOTAL GOVERNMENT COST	68,571	25,532	336,505	11,269	356,011	169,226	565,858
TOTAL PATIENT COST	15,502	14,182	99,158	3,391	148,796	75,303	36,701
TOTAL GOVT AND PATIENT COST	84,073	39,714	435,663	14,660	504,807	244,529	602,559
AVG GOVT COST PER ADMISSION	4,897.93	4,255.33	9,614.43	11,269.00	4,139.66	9,954.47	2,135.31
AVG GOVT COST PER DAY	993.78	1,418.44	457.83	11,269.00	1,171.09	2,820.43	806.07
IV OUTPATIENT PROFESSIONAL SERVICE							
USER BENEFICIARIES	1,568	119	1,490	52	4,986	1,060	3,601
DEPNT OF ACT DUTY SPONSOR	1,131	51	689	35	3,059	437	1,966
RETIREE	80	20	246	3	632	221	301
DEPNT OF RET OR DEC SPONSOR	361	48	558	14	1,314	403	1,351
NUMBER OF VISITS	1,925	2,412	6,724	109	8,105	4,484	6,530
NUMBER OF NON-VISIT SERVICES	2,398	2,288	7,810	123	9,499	2,859	10,020
TOTAL GOVERNMENT COST	121,480	91,590	553,661	6,333	544,664	138,690	479,062
TOTAL PATIENT COST	48,311	274,980	331,874	5,399	369,929	124,728	336,437
TOTAL GOVT AND PATIENT COST	169,791	366,570	885,535	11,732	914,593	263,418	815,499
AVG GOVT COST PER VISIT	63.11	37.97	82.34	58.10	67.20	30.93	73.36
V OUTPATIENT CARE COST SHARED AS INPATIENT							
USER BENEFICIARIES	0	0	0	0	0	0	0
DEPNT OF ACT DUTY SPONSOR	0	0	0	0	0	0	0
RETIREE	0	0	0	0	0	0	0
DEPNT OF RET OR DEC SPONSOR	0	0	0	0	0	0	0
TOTAL GOVERNMENT COST	0	0	0	0	0	0	0
TOTAL PATIENT COST	0	0	0	0	0	0	0
TOTAL GOVT AND PATIENT COST	0	0	0	0	0	0	0

VI TOTAL INPATIENT AND OUTPATIENT CARE							
USER BENEFICIARIES	1,596	138	1,537	63	5,136	1,076	3,850
DEPNT OF ACT DUTY SPONSOR	1,142	56	710	42	3,103	439	2,184
RETIREE	87	26	260	5	686	224	313
DEPNT OF RET OR DEC SPONSOR	371	56	570	16	1,370	414	1,386
TOTAL GOVERNMENT COST	190,051	117,122	890,167	17,602	900,675	307,916	1,044,920
TOTAL PATIENT COST	63,812	289,162	431,032	8,790	518,725	200,031	373,138
TOTAL GOVT AND PATIENT COST	253,863	406,284	1,321,199	26,392	1,419,400	507,947	1,418,058

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CHAMPUS HEALTH CARE SUMMARY BY PRIMARY DIAGNOSIS
BASED ON CARE RECEIVED FROM OCT 1995 THRU SEP 1996

********** CATEGORY OF CARE **********

	NOT USED	OB-STETRICS	GYNE-COLOGY	OPHTHAL-MOLOGY	MENTAL HEALTH	DRUGS	SPECIAL PEDIATRICS
I INPATIENT HOSPITAL SERVICES							
USER BENEFICIARIES	0	283	11	0	94	0	11
DEPNT OF ACT DUTY SPONSOR	0	264	5	0	64	0	11
RETIREE	0	1	0	0	1	0	0
DEPNT OF RET OR DEC SPONSOR	0	18	6	0	29	0	0
TOTAL HOSPITAL ADMISSIONS	0	307	9	0	113	0	11
HOSPITAL DAYS	0	641	251	0	2,732	0	116
AVERAGE LENGTH OF STAY (DAYS)	0.00	2.09	27.89	0.00	24.18	0.00	10.55
AVERAGE DAILY PATIENT LOAD	0.00	1.76	0.69	0.00	7.48	0.00	0.32
TOTAL GOVERNMENT COST	0	903,797	56,999	0	1,316,905	0	134,531
TOTAL PATIENT COST	0	37,531	36,661	0	96,500	0	67,617
TOTAL GOVT AND PATIENT COST	0	941,328	93,660	0	1,413,405	0	202,148
AVG GOVT COST PER ADMISSION	0.00	2,943.96	6,333.22	0.00	11,654.03	0.00	12,230.09
AVG GOVT COST PER DAY	0.00	1,409.98	227.09	0.00	482.03	0.00	1,159.75
II INPATIENT PROFESSIONAL SERVICES							
USER BENEFICIARIES	0	994	89	13	123	0	102
DEPNT OF ACT DUTY SPONSOR	0	918	49	10	59	0	93
RETIREE	0	1	1	1	9	0	0
DEPNT OF RET OR DEC SPONSOR	0	79	39	2	55	0	15
NUMBER OF VISITS	0	1,475	72	1	1,017	0	599
NUMBER OF NON-VISIT SERVICES	0	8,327	130	4	5	0	227
TOTAL GOVERNMENT COST	0	906,256	39,295	2,615	53,036	0	89,194
TOTAL PATIENT COST	0	83,997	26,155	701	22,284	0	16,273
TOTAL GOVT AND PATIENT COST	0	990,253	65,450	3,316	75,320	0	105,467

III TOTAL INPATIENT SERVICES							
USER BENEFICIARIES	0	1,003	93	13	157	0	108
DEPNT OF ACT DUTY SPONSOR	0	924	50	10	82	0	99
RETIREE	0	1	1	1	9	0	0
DEPNT OF RET OR DEC SPONSOR	0	82	42	2	66	0	15
TOTAL GOVERNMENT COST	0	1,810,053	96,294	2,615	1,369,941	0	223,724
TOTAL PATIENT COST	0	121,529	62,816	701	118,784	0	83,890
TOTAL GOVT AND PATIENT COST	0	1,931,582	159,110	3,316	1,488,725	0	307,614
AVG GOVT COST PER ADMISSION	0.00	5,895.94	10,699.33	0.00	12,123.37	0.00	20,338.55
AVG GOVT COST PER DAY	0.00	2,823.80	383.64	0.00	501.44	0 .00	1,928.66
IV OUTPATIENT PROFESSIONAL SERVICES							
USER BENEFICIARIES	0	22	1,650	1,271	4,019	6,077	735
DEPNT OF ACT DUTY SPONSOR	0	21	785	705	2,032	2,636	201
RETIREE	0	0	16	186	361	926	232
DEPNT OF RET OR DEC SPONSOR	0	1	854	382	1,690	2,594	307
NUMBER OF VISITS	0	14	2,062	2,022	50,939	0	2,088
NUMBER OF NON-VISIT SERVICES	0	24	6,715	816	5,364	58,304	5,910
TOTAL GOVERNMENT COST	0	7,574	238,553	144,348	3,381,639	1,516,188	206,145
TOTAL PATIENT COST	0	1,692	205,573	170,314	1,460,589	914,763	90,260
TOTAL GOVT AND PATIENT COST	0	9,266	444,126	314,662	4,842,228	2,430,951	296,405
AVG GOVT COST PER VISIT	0.00	541.00	115.69	71.39	66.39	0.00	98.73
V OUTPATIENT CARE COST SHARED AS INPATIENT							
USER BENEFICIARIES	0	0	0	0	0	0	0
DEPNT OF ACT DUTY SPONSOR	0	0	0	0	0	0	0
RETIREE	0	0	0	0	0	0	0
DEPNT OF RET OR DEC SPONSOR	0	0	0	0	0	0	0
TOTAL GOVERNMENT COST	0	0	0	0	0	0	0
TOTAL PATIENT COST	0	0	0	0	0	0	0
TOTAL GOVT AND PATIENT COST	0	0	0	0	0	0	0

VI TOTAL INPATIENT AND OUTPATIENT CARE							
USER BENEFICIARIES	0	1,006	1,690	1,281	4,064	6,077	825
DEPNT OF ACT DUTY SPONSOR	0	926	810	713	2,050	2,636	283
RETIREE	0	1	16	187	370	926	232
DEPNT OF RET OR DEC SPONSOR	0	83	869	383	1,709	2,594	321
TOTAL GOVERNMENT COST	0	1,817,627	334,847	146,963	4,751,580	1,516,188	429,870
TOTAL PATIENT COST	0	123,221	268,389	171,016	1,579,374	914,763	174,150
TOTAL GOVT AND PATIENT COST	0	1,940,848	603,236	317,979	6,330,954	2,430,951	604,020

NOTE: REFER TO PAGE 1 (SPECIFICATIONS PAGE) OF THIS REPORT FOR CLARIFICATION OF THE DATA WHICH APPEARS ON THIS REPORT.

RUN TIME: 09:52:54 123 - DEWITT AH FT BELVOIR, VA

MODE: 7B,BENE ZIP UNDUPLICATED

I INPATIENT HOSPITAL SERVICES

APPENDIX C

DACH's FY96 Inpatient Workload by DRG

FY96 DACH INPT WORKLOAD

DRG	DESCRIPTION	#Cases	WtdVal	Cost per Case	DRG CHAMPUS Cost	
6	Carpal Tunnel Release	17	0.8124	$3,959.76	$67,315.91	
7	Periaph & Cranial Nerve & Other Nerv Syst Proc w CC	1	2.6017	$12,681.08	$12,681.08	
8	Periaph & Cranial Nerve & Other Nerv Syst Proc w/o CC	12	1.1794	$5,748.57	$68,982.87	DeWitt's
12	Degenerative Nervous System Disorders	1	0.9891	$4,821.02	$4,821.02	FY96
13	Multiple Sclerosis & Cerebellar Ataxia	3	0.7858	$3,830.11	$11,490.32	ASA Rate
14	Specific Cerebrovascular Disorders Except TIA	12	1.2065	$5,880.66	$70,567.94	$4,874.15
15	Transient Ischemic Attack & Precerebral Occlusions	14	0.7227	$3,522.55	$49,315.67	
18	Cranial & Peripheral Nerve Disorders w CC	1	0.9242	$4,504.69	$4,504.69	
19	Cranial & Peripheral Nerve Disorders w/o CC	1	0.599	$2,919.62	$2,919.62	
20	Nervous System Infection Except Viral Meningitis	2	2.1157	$10,312.24	$20,624.48	
21	Viral Meningitis	4	1.535	$7,481.82	$29,927.28	
24	Seizure & Headache Age >17 w CC	11	0.9908	$4,829.31	$53,122.39	
25	Seizure & Headache Age >17 w/o CC	7	0.5681	$2,769.00	$19,383.03	
26	Seizure & Headache Age 0-17	5	0.8993	$4,383.32	$21,916.62	
27	Traumatic Stupor & Coma, Coma >1 HR	2	1.3476	$6,568.40	$13,136.81	
32	Concussion Age >17 w/o CC	2	0.4819	$2,348.85	$4,697.71	
34	Other Disorders of Nervous System w CC	2	1.0569	$5,151.49	$10,302.98	
39	Lens Procedures with or without Vitrectomy	79	0.5306	$2,586.22	$204,311.70	
40	Extraocular Procedures Except Orbit Age >17	10	0.7	$3,411.91	$34,119.05	
41	Extraocular Procedures Except Orbit Age 0-17	15	0.3244	$1,581.17	$23,717.61	
42	Intraocular Procedures Except Retina, Iris & Lens	4	0.5615	$2,736.84	$10,947.34	
44	Acute Major Eye Infections	2	0.615	$2,997.60	$5,995.20	
46	Other Disorders of the Eye Age >17 w CC	2	0.7593	$3,700.94	$7,401.88	
47	Other Disorders of the Eye Age >17 w/o CC	5	0.4539	$2,212.38	$11,061.88	
48	Other Disorders of the Eye Age 0-17	1	0.2859	$1,393.52	$1,393.52	
53	Sinus & Mastoid Procedures Age >17	1	0.9392	$4,577.80	$4,577.80	
54	Sinus & Mastoid Procedures Age 0-17	1	0.4634	$2,258.68	$2,258.68	
55	Miscellaneous Ear, Nose, Mouth & Throat Procedures	1	0.7238	$3,527.91	$3,527.91	
56	Rhinoplasty	18	0.8195	$3,994.37	$71,898.59	
57	T&A Proc, Except Tonsillectomy &/or Adenoidectomy Only, Age >17	1	1.045	$5,093.49	$5,093.49	
59	Tonsillectomy & or Adenoidectomy Only, Age >17	10	0.5963	$2,906.46	$29,064.56	
60	Tonsillectomy & or Adenoidectomy Only, Age 0-17	103	0.2004	$976.78	$100,608.30	
61	Myringotomy w Tube Insertion Age >17	3	1.2221	$5,956.70	$17,870.10	
62	Myringotomy w Tube Insertion Age 0-17	75	0.2837	$1,382.80	$103,709.73	
63	Other Ear, Nose, Mouth & Throat OR Procedures	5	1.1462	$5,586.75	$27,933.75	
65	Dysequilibrium	8	0.5162	$2,516.04	$20,128.29	

68	Otitis Media & URI Age >17 w CC	5	0.7094	$3,457.72	$17,288.61	
69	Otitis Media & URI Age 0-17 w/o CC	5	0.527	$2,568.68	$12,843.39	
70	Otitis Media & URI Age 0-17	17	0.3129	$1,525.12	$25,927.07	
71	Laryngotracheitis	4	0.7206	$3,512.31	$14,049.25	
72	Nasal Trauma & Deformity	3	0.6419	$3,128.72	$9,386.15	
73	Other Ear, Nose, Mouth, Throat Diagnosis Age >17	5	0.773	$3,767.72	$18,838.59	
74	Other Ear, Nose, Mouth, Throat Diagnosis Age 0-17	39	0.3223	$1,570.94	$61,266.60	
78	Pulmonary Embolism	2	1.4136	$6,890.10	$13,780.20	
79	Respiratory Infections & Inflammations Age >17 w CC	4	1.6625	$8,103.27	$32,413.10	
83	Major Chest Trauma w CC	1	0.9557	$4,658.23	$4,658.23	
85	Pleural Effusion w CC	4	1.1917	$5,808.52	$23,234.10	
86	Pleural Effusion w CC	1	0.6848	$3,337.82	$3,337.82	
87	Pulmonary Edema & Respiratory Failure	1	1.3589	$6,623.48	$6,623.48	
88	Chronic Obstructive Pulmonary Disease	31	1.0018	$4,882.92	$151,370.63	
89	Simple Pnuemonia & Pleurisy Age >17 w CC	49	1.1211	$5,464.41	$267,756.07	
90	Simple Pnuemonia & Pleurisy Age >17 w/o CC	7	0.6996	$3,409.96	$23,869.69	
91	Simple Pnuemonia & Pleurisy Age 0-17	27	0.8366	$4,077.71	$110,098.28	
92	Interstitial Lung Disease w CC	1	1.2	$5,848.98	$5,848.98	
93	Interstitial Lung Disease w/o CC	1	0.755	$3,679.98	$3,679.98	
94	Pnuemothorax w CC	1	1.2378	$6,033.22	$6,033.22	
95	Pnuemothorax w/o CC	6	0.6242	$3,042.44	$18,254.67	
96	Bronchitis & Asthma Age >17 w CC	16	0.839	$4,089.41	$65,430.59	
97	Bronchitis & Asthma Age >17 w/o CC	19	0.6089	$2,967.87	$56,389.53	
98	Bronchitis & Asthma Age 0-17	77	0.6696	$3,263.73	$251,307.27	
99	Respiratory Signs & Symptoms w CC	4	0.6959	$3,391.92	$13,567.68	
100	Respiratory Signs & Symptoms w/o CC	5	0.5034	$2,453.65	$12,268.24	
101	Other Respiratory Diagnoses w CC	5	0.912	$4,445.22	$22,226.12	
102	Other Respiratory System Diagnoses w/o CC	2	0.5595	$2,727.09	$5,454.17	
120	Other Circulatory System OR Procedures	1	1.9531	$9,519.70	$9,519.70	
121	Circulatory Disorders w AMI & CV Comp Disch Alive	26	1.6459	$8,022.36	$208,581.45	
122	Circulatory Disorders w AMI w/o CV Comp Disch Alive	23	1.1614	$5,660.84	$130,199.27	
123	Circulatory Disorders w AMI Expired	4	1.437	$7,004.15	$28,016.61	
126	Acute & Subacute Endocarditis	1	2.6049	$12,696.67	$12,696.67	
127	Heart Failure & Shock	37	1.0302	$5,021.35	$185,789.93	
128	Deep Vein Thrombophlebitis	1	0.7929	$3,864.71	$3,864.71	
129	Cardiac Arrest, Unexplained	1	1.1376	$5,544.83	$5,544.83	
130	Peripheral Vascular Disorders w CC	17	0.9384	$4,573.90	$77,756.34	

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131	Peripheral Vascular Disorders w/o CC	17	0.6002	$2,925.46	$49,732.90	
132	Atherosclerosis w CC	23	0.6861	$3,344.15	$76,915.55	
133	Atherosclerosis w/o CC	8	0.5347	$2,606.21	$20,849.66	
134	Hypertension	9	0.58	$2,827.01	$25,443.06	
135	Cardiac Congenital & Valvular Disorders Age >17 w CC	1	0.8988	$4,380.89	$4,380.89	
138	Cardiac Arrthymia & Conduction Disorders w CC	38	0.8049	$3,923.20	$149,081.73	
139	Cardiac Arrthymia & Conduction Disorders w/o CC	34	0.4945	$2,410.27	$81,949.08	
140	Angina Pectoris	57	0.6312	$3,076.56	$175,364.12	
141	Syncope & Collapse w CC	10	0.7149	$3,484.53	$34,845.30	
142	Syncope & Collapse w/o CC	5	0.5216	$2,542.36	$12,711.78	
143	Chest Pain	139	0.5159	$2,514.57	$349,525.78	
144	Other Circulatory System Diagnoses w CC	4	1.0689	$5,209.98	$20,839.92	
145	Other Circulatory System Diagnoses w/o CC	4	0.6204	$3,023.92	$12,095.69	
148	Major Small & Large Bowel Procedures w CC	15	3.3264	$16,213.37	$243,200.59	
149	Major Small & Large Bowel Procedures w CC	15	1.5654	$7,629.99	$114,449.92	
150	Peritoneal Adhesiolysis w CC	3	2.6561	$12,946.23	$38,838.69	
151	Peritoneal Adhesiolysis w/o CC	2	1.2606	$6,144.35	$12,288.71	
152	Minor Small & Large Bowel Procedures w CC	1	1.886	$9,192.65	$9,192.65	
153	Minor Small & Large Bowel Procedures w CC	1	1.1257	$5,486.83	$5,486.83	
154	Stomach, Esophageal & Duodenal Procedures Age >17 w CC	2	4.2102	$20,521.15	$41,042.29	
155	Stomach, Esophageal & Duodenal Procedures Age >17 w/o CC	1	1.3885	$6,767.76	$6,767.76	
157	Anal & Stomal Procedures w CC	5	1.1048	$5,384.96	$26,924.80	
158	Anal & Stomal Procedures w/o CC	39	0.5789	$2,821.65	$110,044.17	
159	Hernia Procedures Except Inguinal & Femoral Age >17 w CC	6	1.1707	$5,706.17	$34,237.00	
160	Hernia Procedures Except Inguinal & Femoral Age >17 w/o CC	24	0.6746	$3,288.10	$78,914.44	
161	Inguinal & Femoral Hernia Procedures Age >17 w CC	17	0.9554	$4,656.76	$79,164.97	
162	Inguinal & Femoral Hernia Procedures Age >17 w/o CC	76	0.5365	$2,614.98	$198,738.59	
163	Hernia Procedures Age 0-17	15	0.7578	$3,693.63	$55,404.46	
164	Appendectomy w Complicated Principal Diag w CC	6	2.2374	$10,905.42	$65,432.54	
165	Appendectomy w Complicated Principal Diag w/o CC	4	1.2365	$6,026.89	$24,107.55	
166	Appendectomy w/o Complicated Principal Diag w CC	5	1.3695	$6,675.15	$33,375.74	
167	Appendectomy w/o Complicated Principal Diag w/o CC	44	0.7892	$3,846.68	$169,253.88	
168	Mouth Procedures w CC	1	1.1761	$5,732.49	$5,732.49	
169	Mouth Procedures w/o CC	4	0.6434	$3,136.03	$12,544.11	
171	Other Digestive System OR Procedures w CC	1	1.1628	$5,667.66	$5,667.66	
172	Digestive Malignancy w CC	2	1.2898	$6,286.68	$12,573.36	
173	Digestive Malignancy w/o CC	9	0.6569	$3,201.83	$28,816.46	

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174	GI Hemorrhage w CC	42	0.988	$4,815.66	$202,257.73	
175	GI Hemorrhage w/o CC	15	0.5457	$2,659.82	$39,897.35	
176	Complicated Peptic Ulcer	2	1.0563	$5,148.56	$10,297.13	
177	Uncomplicated Peptic Ulcer w CC	2	0.827	$4,030.92	$8,061.84	
178	Uncomplicated Peptic Ulcer w/o CC	18	0.599	$2,919.62	$52,553.09	
179	Inflammatory Bowel Disease	15	1.0993	$5,358.15	$80,372.30	
180	GI Obstruction w CC	11	0.924	$4,503.71	$49,540.86	
181	GI Obstruction w/o CC	14	0.5231	$2,549.67	$35,695.35	
182	Esophagitis, Gastroent & Misc Digest Disorders Age >17 w CC	60	0.7794	$3,798.91	$227,934.75	
183	Esophagitis, Gastroent & Misc Digest Disorders Age >17 w/o CC	206	0.548	$2,671.03	$550,233.05	
184	Esophagitis, Gastroent & Misc Digest Disorders 0-17	51	0.391	$1,905.79	$97,195.43	
185	Dental & Oral Dis Except Extractions & Restorations, Age >17	2	0.8892	$4,334.09	$8,668.19	
187	Dental Extractions & Restorations	33	0.6473	$3,155.04	$104,116.23	
188	Other Digestive System Diagnoses Age >17 w CC	11	1.0458	$5,097.39	$56,071.25	
189	Other Digestive System Diagnoses Age >17 w/o CC	117	0.5438	$2,650.56	$310,115.84	
190	Other Digestive System Diagnoses Age 0-17	3	1.2379	$6,033.71	$18,101.13	
191	Pancreas, Liver & Shunt Procedures w CC	1	4.4495	$21,687.53	$21,687.53	
195	Cholecystectomy w CDE w CC	1	2.6147	$12,744.44	$12,744.44	
196	Cholecystectomy w CDE w/o CC	1	1.5695	$7,649.98	$7,649.98	
197	Cholecystectomy Except by Laparoscope w/o CDE w CC	3	2.2034	$10,739.70	$32,219.11	
198	Cholecystectomy Except by Laparoscope w/o CDE w/o CC	3	1.1355	$5,534.60	$16,603.79	
202	Cirrhosis & Alcoholic Hepatitis	2	1.3177	$6,422.67	$12,845.33	
203	Malignancy of Hepatobiliary System or Pancreas	2	1.2187	$5,940.13	$11,880.25	
204	Disorders of Pancreas Except Malignancy	24	1.202	$5,858.73	$140,609.48	
205	Disorders of Liver Except Malig, Cirr, ALC Hepa w CC	2	1.2276	$5,983.51	$11,967.01	
206	Disorders of Liver Except Malig, Cirr, ALC Hepa w/o CC	3	0.6801	$3,314.91	$9,944.73	
207	Disorders of the Biliary Tract w CC	9	1.0287	$5,014.04	$45,126.34	
208	Disorders of the Biliary Tract w/o CC	13	0.5943	$2,896.71	$37,657.20	
210	Hip & Femur Procedures Except Major Joint Age >17 w CC	2	1.8616	$9,073.72	$18,147.44	
211	Hip & Femur Procedures Except Major Joint Age >17 w/o CC	2	1.2893	$6,284.24	$12,568.48	
212	Hip & Femur Procedures Except Major Joint Age 0-17	1	1.1296	$5,505.84	$5,505.84	
217	WND Debrid & SKN GRFT Except Hand, For Muscskelet & Conn Tiss Di	6	2.8975	$14,122.85	$84,737.10	
218	Lower Extrem & Humer Proc Except Hip,Foot,Femur Age >17 w CC	3	1.4231	$6,936.40	$20,809.21	
219	Lower Extrem & Humer Proc Except Hip,Foot,Femur Age >17 w/o CC	53	0.9179	$4,473.98	$237,121.06	
220	Lower Extrem & Humer Proc Except Hip,Foot,Femur Age 0-17	18	0.5611	$2,734.89	$49,227.94	
221	Knee Procedures w CC	6	1.8463	$8,999.14	$53,994.86	
222	Knee Procedures w/o CC	180	0.9747	$4,750.83	$855,150.12	

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223	Major Shoulder/Elbow Proc, or Other Upper Extremity Proc w CC	33	0.8364	$4,076.74	$134,532.39	
224	Shoulder,Elbow or Forearm Proc, EXC Major Joint Proc, w/o CC	31	0.6983	$3,403.62	$105,512.19	
225	Foot Procedures	77	0.9504	$4,632.39	$356,694.20	
226	Soft Tissue Procedures w CC	4	1.3656	$6,656.14	$26,624.56	
227	Soft Tissue Procedures w/o CC	33	0.7273	$3,544.97	$116,983.99	
228	Major Thumb or Joint Proc, or OTH Hand OR Wrist Proc w CC	6	0.9315	$4,540.27	$27,241.62	
229	Hand or Wrist Proc, Except Major Hoint Proc, w/o CC	46	0.5965	$2,907.43	$133,741.80	
230	Local Excision & Removal of Int Fix Devices of Hip & Femur	3	1.0399	$5,068.63	$15,205.89	
231	Local Excision & Removal of Int Fix Devices Except Hip & Femur	124	1.2131	$5,912.83	$733,191.09	
232	Arthroscopy	20	1.0578	$5,155.88	$103,117.52	
233	Other Musculoskelet Sys & Conn Tiss OR Proc w CC	2	1.9275	$9,394.92	$18,789.85	
234	Other Musculoskelet Sys & Conn Tiss OR Proc w/o CC	7	1.0039	$4,893.16	$34,252.11	
235	Fractures of Femur	3	0.8501	$4,143.51	$12,430.54	
236	Fractures of Hip & Pelvis	5	0.7818	$3,810.61	$19,053.05	
238	Osteomyelitis	1	1.4356	$6,997.33	$6,997.33	
240	Connective Tissue Disorders w CC	2	1.19	$5,800.24	$11,600.48	
241	Connective tissue Disorders w/o CC	2	0.5986	$2,917.67	$5,835.33	
242	Septic Arthritis	1	1.1295	$5,505.35	$5,505.35	
243	Medical Back Problems	10	0.7248	$3,532.78	$35,327.84	
244	Bone Diseases & Specific Arthropathies w CC	3	0.7446	$3,629.29	$10,887.88	
247	Signs & Symptoms of Musculoskeletal System & Conn Tiss	6	0.5534	$2,697.35	$16,184.13	
248	Tendonitis, Myositis & Bursitis	5	0.7275	$3,545.94	$17,729.72	
249	Aftercare, Musculoskeletal System & Connective Tissue	5	0.6558	$3,196.47	$15,982.34	
250	FX, SPRN, STRN & DISL of Forearm, Hand, Foot Age >17 w CC	1	0.7193	$3,505.98	$3,505.98	
251	FX, SPRN, STRN & DISL of Forearm, Hand, Foot Age >17 w/o CC	4	0.4423	$2,155.84	$8,623.35	
252	FX, SPRN, STRN & DISL of Forearm, Hand, Foot Age 0-17	6	0.2438	$1,188.32	$7,129.91	
253	FX, SPRN, STRN & DISL of Uparm,Lowleg Ex Foot Age >17 w CC	3	0.7627	$3,717.51	$11,152.54	
254	FX, SPRN, STRN & DISL of Uparm,Lowleg Ex Foot Age >17 w/o CC	5	0.4365	$2,127.57	$10,637.83	
255	FX, SPRN, STRN & DISL of Uparm,Lowleg Ex Foot Age 0-17	1	0.2838	$1,383.28	$1,383.28	
256	Other Musculoskeletal System & Connective Tissue Diagnoses	6	0.6419	$3,128.72	$18,772.30	
257	Total Mastectomy for Malignancy w CC	8	0.8997	$4,385.27	$35,082.18	
258	Total Mastectomy for Malignancy w/o CC	3	0.6965	$3,394.85	$10,184.54	
259	Subtotal Mastectomy for Malignancy w CC	4	0.8765	$4,272.19	$17,088.77	
260	Subtotal Mastectomy for Malignancy w CC	37	0.5749	$2,802.15	$103,679.51	
261	Breast Proc for Non-malignancy Except Biopsy & Local Excision	28	0.808	$3,938.31	$110,272.77	
262	Breast Biopsy & Local Excision for Non-malignancy	128	0.7115	$3,467.96	$443,898.59	
263	Skin Graft &/or Debrid for SKN Ulcer or Cellulitis w CC	1	2.2344	$10,890.80	$10,890.80	

264	Skin Graft &/or Debrid for SKN Ulcer or Cellulitis w/o CC	3	1.1633	$5,670.10	$17,010.30	
265	Skin Graft &/or Debrid Except for SKN Ulcer or Cellulitis w CC	2	1.4131	$6,887.66	$13,775.32	
266	Skin Graft &/or Debrid Except for SKN Ulcer or Cellulitis w/o CC	3	0.7451	$3,631.73	$10,895.19	
267	Perianal & Pilondial Procedures	9	0.8022	$3,910.04	$35,190.39	
269	Other Skin, Subcut Tiss & Breast Proc w CC	1	1.6495	$8,039.91	$8,039.91	
270	Other Skin, Subcut Tiss & Breast Proc w/o CC	45	0.6796	$3,312.47	$149,061.26	
271	Skin Ulcers	1	1.1157	$5,438.09	$5,438.09	
276	Non-malignant Breast Disorders	5	0.6418	$3,128.23	$15,641.15	
277	Cellulitis Age >17 w CC	27	0.8703	$4,241.97	$114,533.26	
278	Cellulitis Age >17 w/o CC	23	0.5822	$2,837.73	$65,267.79	
279	Cellulitis Age 0-17	6	0.707	$3,446.02	$20,676.14	
281	Trauma to the Skin, Subcut Tiss & Breast Age >17 w/0 CC	4	0.4523	$2,204.58	$8,818.31	
283	Minor Skin Disorders w CC	4	0.7171	$3,495.25	$13,981.01	
284	Minor Skin Disorders w/o CC	9	0.4307	$2,099.30	$18,893.67	
294	Diabetes Age >35	22	0.7579	$3,694.12	$81,270.60	
295	Diabetes Age 0-35	10	0.7634	$3,720.93	$37,209.26	
296	Nutritional & Misc Metabolic Disorders Age >17 w CC	7	0.9166	$4,467.65	$31,273.52	
297	Nutritional & Misc Metabolic Disorders Age >17 w/o CC	9	0.5353	$2,609.13	$23,482.19	
298	Nutritional & Misc Metabolic Disorders Age 0-17	4	0.4756	$2,318.15	$9,272.58	
299	Inborn errors of Metabolism	2	0.979	$4,771.79	$9,543.59	
300	Endocrine Disorders w CC	1	1.0919	$5,322.08	$5,322.08	
301	Endocrine Disorders w/o CC	2	0.6181	$3,012.71	$6,025.42	
308	Minor Bladder Procedures wCC	5	1.4848	$7,237.14	$36,185.69	
309	Minor Bladder Procedures w/o CC	1	0.8061	$3,929.05	$3,929.05	
310	Transurethral Procedures w CC	7	0.9694	$4,725.00	$33,075.01	
311	Transurethral Procedures w/o CC	3	0.5486	$2,673.96	$8,021.88	
312	Urethral Procedures, Age >17 w CC	2	0.8891	$4,333.61	$8,667.21	
313	Urethral Procedures, Age >17 w/o CC	5	0.5008	$2,440.97	$12,204.87	
315	Other Kidney & Urinary Tract OR Procedures	1	2.0612	$10,046.60	$10,046.60	
316	Renal Failure	5	1.2996	$6,334.45	$31,672.23	
319	Kidney & Urinary Tract Neoplasms w/o CC	1	0.5432	$2,647.64	$2,647.64	
320	Kidney & Urinary Tract Infections Age >17 w CC	31	0.932	$4,542.71	$140,823.94	
321	Kidney & Urinary Tract Infections Age >17 w/o CC	8	0.6104	$2,975.18	$23,801.45	
322	Kidney & Urinary Tract Infections Age 0-17	15	0.6651	$3,241.80	$48,626.96	
323	Urinary Stones w CC, &/or ESW Lithrotripsy	10	0.7281	$3,548.87	$35,488.69	
324	Urinary Stones w/o CC	20	0.3992	$1,945.76	$38,915.21	
325	Kidney & Urinary Tract Signs & Symptoms Age >17 w CC	3	0.6436	$3,137.00	$9,411.01	

326	Kidney & Urinary Tract Signs & Symptoms Age >17 w/o CC	1	0.4233	$2,063.23	$2,063.23	
331	Other Kidney & Urinary Tract Diagnoses Age >17 w CC	1	1.0122	$4,933.61	$4,933.61	
332	Other Kidney & Urinary Tract Diagnoses Age >17 w/o CC	2	0.6176	$3,010.28	$6,020.55	
333	Other Kidney & Urinary Tract Diagnoses Age 0-17	2	0.8701	$4,241.00	$8,482.00	
334	Major Male Pelvic Procedures w CC	3	1.6948	$8,260.71	$24,782.13	
335	Major Male Pelvic Procedures w/o CC	1	1.3044	$6,357.84	$6,357.84	
336	Transurethral Prostatectomy w CC	3	0.8802	$4,290.23	$12,870.68	
337	Transurethral Prostatectomy w/o CC	1	0.6128	$2,986.88	$2,986.88	
338	Testes Procedures, for Malignancy	1	1.026	$5,000.88	$5,000.88	
339	Testes Procedures, Non-malignancy Age >17	14	0.933	$4,547.58	$63,666.15	
340	Testes Procedures, Non-malignancy Age 0-17	15	0.2723	$1,327.23	$19,908.47	
341	Penis Procedures	3	1.0699	$5,214.85	$15,644.56	
342	Circumcision Age >17	5	0.736	$3,587.37	$17,936.87	
343	Circumcision Age 0-17	11	0.1479	$720.89	$7,929.75	
346	Malignancy, Male Reproductive System, w CC	1	0.9626	$4,691.86	$4,691.86	
347	Malignancy, Male Reproductive System, w/o CC	1	0.4853	$2,365.42	$2,365.42	
348	Benign Prostatic Hypertrophy w CC	1	0.7106	$3,463.57	$3,463.57	
350	Inflammation of the Male Reproductive System	11	0.681	$3,319.30	$36,512.26	
351	Sterilization, Male	2	0.2271	$1,106.92	$2,213.84	
352	Other Male Reproductive System Diagnoses	3	0.5932	$2,891.35	$8,674.04	
355	Uterine,Adnexa Proc for Non-ovarian/Adnexal Malig w/o CC	2	0.8881	$4,328.73	$8,657.47	
356	Female Reproductive System Reconstructive Procedures	13	0.7323	$3,569.34	$46,401.42	
358	Uterine & Adnexa Proc for Non-malignancy w CC	52	1.1458	$5,584.80	$290,409.66	
359	Uterine & Adnexa Proc for Non-malignancy w CC	85	0.8072	$3,934.41	$334,425.18	
360	Vagina, Cervix, & Vulva Procedures	27	0.8739	$4,259.52	$115,007.03	
361	Laparoscopy & Incisional Tubal Interruption	28	1.1984	$5,841.18	$163,553.08	
362	Endoscopic Tubal Interruption	59	0.2902	$1,414.48	$83,454.22	
363	D&C, Conization & Radio-Implant, for Malignancy	6	0.6881	$3,353.90	$20,123.42	
364	D&C, Conization Except for Malignancy	37	0.6667	$3,249.60	$120,235.04	
368	Infections, Female Reproductive System	7	0.9841	$4,796.65	$33,576.56	
369	Menstrual & Other Female Reproductive System Disorders	10	0.513	$2,500.44	$25,004.39	
370	Cesarean Section w CC	111	0.9573	$4,666.02	$517,928.64	
371	Cesarean Section w/o CC	89	0.6531	$3,183.31	$283,314.36	
372	Vaginal Delivery w Complicating Diagnoses	142	0.5558	$2,709.05	$384,685.46	
373	Vaginal Delivery w/o Complicating Diagnoses	659	0.3446	$1,679.63	$1,106,877.55	
374	Vaginal Delivery w Sterilization &/or D&C	23	0.6721	$3,275.92	$75,346.07	
376	Postpartum & Post Abortion Diagnoses w/o OR Procedure	8	0.4418	$2,153.40	$17,227.20	

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377	Postpartum & Post Abortion Diagnoses w OR Procedure	8	0.8181	$3,987.54	$31,900.34	
378	Ectopic Pregnancy	28	0.7409	$3,611.26	$101,115.22	
379	Threatened Abortion	56	0.3962	$1,931.14	$108,143.74	
380	Abortion w/o D&C	6	0.3742	$1,823.91	$10,943.44	
381	Abortion w D&C, Aspiration Curettage or Hysterotomy	82	0.4673	$2,277.69	$186,770.60	
382	False Labor	8	0.1922	$936.81	$7,494.49	
383	Other Antepartum Diagnoses w Medical Complications	141	0.4587	$2,235.77	$315,243.94	
384	Other Antepartum Diagnoses w Medical Complications	58	0.2818	$1,373.54	$79,665.06	
391	Normal Newborn	730	0.1465	$714.06	$521,265.97	
394	Other OR Procedures of the Blood and Blood Forming Organs	10	1.6252	$7,921.47	$79,214.69	
395	Red Blood Cell Disorders Age >17	24	0.8359	$4,074.30	$97,783.25	
396	Red Blood Cell Disorders Age 0-17	3	0.598	$2,914.74	$8,744.23	
397	Coagulation Disorders	1	1.2825	$6,251.10	$6,251.10	
398	Reticuloendothelial & Immunity Disorders w CC	7	1.236	$6,024.45	$42,171.15	
401	Lymphoma & Non-acute Leukemia w Other OR Proc w CC	1	2.4533	$11,957.75	$11,957.75	
402	Lymphoma & Non-acute Leukemia w Other OR Proc w/o CC	1	0.9428	$4,595.35	$4,595.35	
408	Myeloprolif Disord of Poorly Diff Neopl w Other OR Proc	2	1.684	$8,208.07	$16,416.14	
412	History of Malignancy w Endoscopy	35	0.453	$2,207.99	$77,279.65	
413	Other Myeloprolif Dis of Poorly Diff Neopl Diag w CC	1	1.3422	$6,542.08	$6,542.08	
414	Other Myeloprolif Dis of Poorly Diff Neopl Diag w/o CC	1	0.7285	$3,550.82	$3,550.82	
415	OR Procedures for Infectious & Parasitic Diseases	4	3.4769	$16,946.93	$67,787.73	
416	Septicemia Age >17	7	1.477	$7,199.12	$50,393.84	
418	Septicemia Age 0-17	5	0.9777	$4,765.46	$23,827.28	
419	Fever of Unknown Origin Age >17 w CC	7	0.9223	$4,495.43	$31,468.00	
420	Fever of Unknown Origin Age >17 w/o CC	1	0.6258	$3,050.24	$3,050.24	
421	Viral Illness Age >17	9	0.6982	$3,403.13	$30,628.18	
422	Viral Illness & Fever of Unknown Origin Age 0-17	18	0.5446	$2,654.46	$47,780.32	
423	Other Infectious & Parasitic Diseases Diagnoses	1	1.5828	$7,714.80	$7,714.80	
425	Acute Adjust React & Disturbances of Psychosocial Dysfunction	1	0.7129	$3,474.78	$3,474.78	
426	Depressive Neuroses	3	0.5949	$2,899.63	$8,698.90	
429	Organic Disturbances & Mental Retardation	3	0.9537	$4,648.48	$13,945.43	
430	Psychoses	6	0.867	$4,225.89	$25,355.33	
433	Alcohol/Drug Abuse or Deference, Left AMA	4	0.308	$1,501.24	$6,004.95	
434	ALC/Drug Abuse or Defend, Detox or Oth Sympt Treat w CC	14	0.7373	$3,593.71	$50,311.95	
440	Wound Debridements for Injuries	3	1.7792	$8,672.09	$26,016.26	
441	Hand Procedures for Injuries	1	0.8785	$4,281.94	$4,281.94	
442	Other OR Procedures for Injuries w CC	2	2.0836	$10,155.78	$20,311.56	

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443	Other OR Procedures for Injuries w/o CC	9	0.813	$3,962.68	$35,664.16	
445	Traumatic Injury Age >17 w/o CC	4	0.4664	$2,273.30	$9,093.21	
446	Traumatic Injury Age 0-17	3	0.2846	$1,387.18	$4,161.55	
447	Allergic Reactions Age >17	3	0.4976	$2,425.38	$7,276.13	
448	Allergic Reactions Age 0-17	1	0.0896	$436.72	$436.72	
449	Poisoning & Toxic Effects of Drugs Age >17 w CC	9	0.7886	$3,843.75	$34,593.79	
450	Poisoning & Toxic Effects of Drugs Age >17 w/o CC	9	0.4329	$2,110.02	$18,990.18	
451	Poisoning & Toxic Effects of Drugs Age 0-17	15	0.2527	$1,231.70	$18,475.47	
452	Complications of Treatment w CC	5	0.9127	$4,448.64	$22,243.18	
453	Complications of Treatment w/o CC	4	0.4752	$2,316.20	$9,264.78	
454	Other Injury, Poisoning & Toxic Effect Diag w Diag	5	0.8906	$4,340.92	$21,704.59	
455	Other Injury, Poisoning & Toxic Effect Diag w Diag	8	0.4689	$2,285.49	$18,283.91	
461	OR Proc w Diagnoses of Other Contact w Health Services	7	1.0104	$4,924.84	$34,473.89	
463	Signs & Symptoms w CC	11	0.7416	$3,614.67	$39,761.37	
464	Signs & Symptoms w/o CC	2	0.4972	$2,423.43	$4,846.85	
465	Aftercare w History of Malignancy as Secondary Diagnosis	15	0.4362	$2,126.10	$31,891.56	
466	Aftercare w/o History of Malignancy as Secondary Diagnosis	22	0.5601	$2,730.01	$60,060.25	
467	Other Factors Influencing Health Status	40	0.4291	$2,091.50	$83,659.91	
468	Extensive OR Procedure Unrelated to Principal Diagnosis	2	3.5391	$17,250.10	$34,500.21	
473	Acute Leukemia w/o Major OR Procedure Age >17	1	3.4797	$16,960.58	$16,960.58	
475	Respiratory System Diagnosis with Ventillator Support	4	3.7015	$18,041.67	$72,166.66	
477	Non-extensive OR Procedure Unrelated to Principal Diagnosis	6	1.5682	$7,643.64	$45,861.85	
487	Other Multiple Significant Trauma	1	1.9932	$9,715.16	$9,715.16	
493	Laparoscopic Cholecystectomy w/o CDE w CC	8	1.6501	$8,042.83	$64,342.68	
494	Laparoscopic Cholecystectomy w/o CDE w/o CC	38	0.8769	$4,274.14	$162,417.40	
600	Neonate, Died w/in One Day of Birth	5	0.6596	$3,214.99	$16,074.95	
601	Neonate, Transferred <5 Days Old	19	0.4898	$2,387.36	$45,359.81	
614	Neonate, Birthwt 1500-1999G, w/o Signif OR Proc, w Other Prob	1	1.4794	$7,210.82	$7,210.82	
619	Neonate, Birthwt 2000-2499G, w/o Signif OR Proc, w Minor Prob	1	1.9716	$9,609.87	$9,609.87	
621	Neonate, Birthwt 2000-2499G, w/o Signif OR Proc, w Other Prob	12	0.4636	$2,259.66	$27,115.87	
626	Neonate, Birthwt >2499G, w/o Signif OR Proc, w Mult Major Prob	2	2.4222	$11,806.17	$23,612.33	
627	Neonate, Birthwt >2499G, w/o Signif OR Proc, w Major Prob	12	1.0876	$5,301.13	$63,613.51	
628	Neonate, Birthwt >2499G, w/o Signif OR Proc, w Minor Prob	15	0.6469	$3,153.09	$47,296.31	
630	Neonate, Birthwt 1500-1999G, w/o Signif OR Proc, w Other Prob	244	0.2015	$982.14	$239,642.46	
900	ALC/Drug or Depend, Detox or Oth Sympt Treat Age <= 21 w/o	2	0.9865	$4,808.35	$9,616.70	
901	ALC/Drug or Depend, Detox or Oth Sympt Treat Age > 21 w/o	11	0.6063	$2,955.20	$32,507.17	AVG/Case
	Total Cases	6746			$20,348,944.56	$3,016.45

APPENDIX D

MEDCOM Manpower Assessment Survey Results

	MANPOWER SURVEY RESULTS					
PARA	LINE	POSITION	GRADE	CODE	CIV PAY	MIL PAY
881N	9	SECY	GS-7	318	$28,404	
883N	2	TNG CMS SP	E-4	91D	$30,349	
883N	3	CBT CMS SP	E-4	91D	$30,349	
883N	4	CBT CMS SP	E-4	91D	$30,349	
883N	5	MED SUP TEC	GS-4	622	$20,449	
883S	3	CBT OR NUR	O-2	66E		$55,860
883S	8	TNG OR SP	E-4	91D		$30,349
883S	8	TNG OR SP	E-4	91D		$30,349
883S	9	CBT OR SP	E-3	91D		$25,177
883S	9	CBT OR SP	E-3	91D		$25,177
883T	2	CMF OBGYN	O-4	60J		$88,229
883T	4	CMF OBGYN	O-4	60J		$88,229
883T	7	CMF OBGYN NUR	O-4	66H		$88,229
883T	7	CMF OBGYN NUR	O-4	66H		$88,229
883T	11	MED OFF OBGYN	GS-14	602	$74,627	
883T	16	NUR ASST	GS-4	621	$20,499	
885A	1	CMF DEP CDR NSG	O-6	66N		$126,832
885A	6	EXP C WDMSTR	E-8	91C		$58,099
885G	1	CLIN HD NUR	O-3	66H		$74,862
885G	2	MED SURG NUR	O-3	66H		$74,862
885G	3	MED SURG NUR	O-2	66H		$55,860
885G	4	EXP WDMSTR	E-7	91C		$50,086
885G	5	CBT PRAC NUR	E-6	91C		$42,735
885G	6	CBT PRAC NUR	E-5	91C		$36,421
885G	6	CBT PRAC NUR	E-5	91C		$36,421
885G	7	TNG MED SP	E-4	91C		$30,349
885G	8	SUPV NUR SP	GS-12	610	$53,110	
885G	9	NUR SPEC	GS-11	610	$46,641	
885G	9	NUR SPEC	GS-11	610	$46,641	
885G	9	NUR SPEC	GS-11	610	$46,641	
885G	9	NUR SPEC	GS-11	610	$46,641	
885G	10	NUR SPEC	GS-11	610	$46,641	
885G	11	NUR SPEC	GS-11	610	$46,641	
885G	11	NUR SPEC	GS-11	610	$46,641	
885J	1	TNG WDMSTR	E-6	91C		$42,375
885J	2	CBT PRAC NUR	E-5	91C		$36,641
885J	3	TNG MED SP	E-4	91B		$30,349
885J	4	SUPV CLIN NUR	GS-11	610	$45,475	
885J	5	CLIN NUR	GS-10	610	$42,449	
885J	5	CLIN NUR	GS-10	610	$42,449	
885J	5	CLIN NUR	GS-10	610	$42,449	
885J	5	CLIN NUR	GS-10	610	$42,449	
885J	6	CLIN NUR	GS-10	610	$42,449	
885J	7	CLIN NUR	GS-10	610	$42,449	
885J	8	PRAC NUR	GS-5	620	$26,077	
885J	8	PRAC NUR	GS-5	620	$26,077	
885J	9	NUR ASST	GS-5	621	$22,931	

885J	10	NUR ASST	GS-5	621	$22,931	
885J	11	MED CLK (OA)	GS-4	679	$21,607	
885K	6	TNG WDMSTR	E-7	91C		$50,086
885K	7	CBT PRAC NUR	E-6	91C		$42,735
885K	8	CBT PRAC NUR	E-6	91C		$42,735
885K	9	CBT PRAC NUR	E-5	91C		$36,421
885K	10	CBT PRAC NUR	E-5	91C		$36,421
885K	11	TNG MED SP	E-4	91B		$30,349
885K	12	TNG MED SP	E-4	91B		$30,349
885K	13	CBT MED SP	E-3	91B		$25,177
885K	14	CBT MED SP	E-3	91B		$25,177
885K	15	CLIN NUR	GS-11	610	$46,523	
885K	16	CLIN NUR	GS-10	610	$43,341	
885K	17	CLIN NUR	GS-10	610	$43,341	
885K	18	CLIN NUR	GS-10	610	$43,341	
885K	19	CLIN NUR	GS-10	610	$43,341	
885K	20	PRAC NUR	GS-5	620	$26,077	
885K	21	PRAC NUR	GS-5	620	$26,077	
885K	22	NUR ASST	GS-5	621	$22,931	
885K	23	MED CLK (OA)	GS-4	679	$21,607	
885K	24	MED CLK (OA)	GS-4	679	$21,607	
885L	3	CMF MED SURG NUR	O-2	66H		$55,860
885L	3	CMF MED SURG NUR	O-2	66H		$55,860
885L	3	CMF MED SURG NUR	O-2	66H		$55,860
885L	4	CMF MED SURG NUR	O-2	66H		$55,860
885L	4	CMF MED SURG NUR	O-2	66H		$55,860
885L	4	CMF MED SURG NUR	O-2	66H		$55,860
885L	5	EXP WDMSTR	E-7	91C		$50,086
885L	6	CBT PRAC NUR	E-6	91C		$42,375
885L	6	CBT PRAC NUR	E-6	91C		$42,375
885L	7	CBT PRAC NUR	E-5	91C		$36,421
885L	7	CBT PRAC NUR	E-5	91C		$36,421
885L	8	TNG MED SP	E-4	91B		$30,349
885L	8	TNG MED SP	E-4	91B		$30,349
885L	8	TNG MED SP	E-4	91B		$30,349
885L	8	TNG MED SP	E-4	91B		$30,349
885L	9	TNG MED SP	E-3	91B		$25,177
885L	9	TNG MED SP	E-3	91B		$25,177
885L	10	CLIN NUR	GS-11	610	$46,523	
885L	11	CLIN NUR	GS-10	610	$43,341	
885L	11	CLIN NUR	GS-10	610	$43,341	
885L	11	CLIN NUR	GS-10	610	$43,341	
885L	11	CLIN NUR	GS-10	610	$43,341	
885L	12	CLIN NUR	GS-10	610	$43,341	
885L	13	CLIN NUR	GS-10	610	$43,341	
885L	13	CLIN NUR	GS-10	610	$43,341	
885L	13	CLIN NUR	GS-10	610	$43,341	
885L	13	CLIN NUR	GS-10	610	$43,341	
885L	14	PRAC NUR	GS-5	620	$26,077	

885L	14	PRAC NUR	GS-5	620	$26,077	
885L	15	PRAC NUR	GS-5	620	$26,077	
885L	15	PRAC NUR	GS-5	620	$26,077	
885L	16	NUR ASST	GS-4	621	$22,931	
885L	16	NUR ASST	GS-4	621	$22,931	
885L	16	NUR ASST	GS-4	621	$22,931	
885L	17	NUR ASST	GS-4	621	$22,931	
885L	18	MED CLK (OA)	GS-4	679	$21,607	
892	5	TNG RAD SGT	E-5	91P		$36,421
892	8	TNG RAD SP	E-3	91P		$25,177
892	8	TNG RAD SP	E-3	91P		$25,177
892	12	OFF AUTOM CLK	GS-4	326	$21,607	
893	2	CMF PATH	O-4	61U		$88,229
893	6	TNG MED LAB NCO	E-5	91K		$36,421
893	9	TNG MED LAB SP	E-4	91K		$30,349
893	10	TNG MED LAB SP	E-3	91K		$25,177
893	13	MED TECHNO	GS-11	644	$50,139	
894	19	MED TECHNO	GS-9	644	$46,829	
896A	1	EXP CHIEF	O-4	67E		$88,229
896A	4	EXP PHARM NCO	E-7	91Q		$50,086
896A	8	TNG PHARM SGT	E-6	91Q		$42,735
896A	9	TNG PHARM SP	E-4	91Q		$30,349
896A	11	TNG PHARM SP	E-3	91Q		$25,177
896A	13	PHARMACIST	GS-11	660	$50,139	
896A	13	PHARMACIST	GS-11	660	$50,139	
896A	13	PHARMACIST	GS-11	660	$50,139	
896A	13	PHARMACIST	GS-11	660	$50,139	
896A	16	PHARM TECH	GS-5	661	$23,533	
896A	16	PHARM TECH	GS-5	661	$23,533	
896A	16	PHARM TECH	GS-5	661	$23,533	
896A	16	PHARM TECH	GS-5	661	$23,533	
896A	16	PHARM TECH	GS-5	661	$23,533	
896A	16	PHARM TECH	GS-5	661	$23,533	
896A	17	PHARM TECH	GS-5	661	$23,533	
896A	17	PHARM TECH	GS-5	661	$23,533	
896A	17	PHARM TECH	GS-5	661	$23,533	
896B	4	TNG MED EQ REP	E-5	91A		$36,421
896B	5	TNG MED EQ REP	E-4	91A		$30,349
896B	6	TNG MED EQ REP	E-3	91A		$25,177
896B	9	MED EQ RPR	GS-11	4805	$38,484	
896F	4	SUP TECH	GS-6	2005	$25,561	
896G	9	MATR HNDLR MVO	GS-5	6907	$27,465	
896G	10	MATR HNDLR FLO	GS-5	6907	$27,465	
896J	2	CUST WK INSP	WG-6	3566	$27,632	
896J	4	LAUNDRY WRK	WG-2	7304	$19,931	
897A	1	EXP CHIEF	O-3	70E		$74,862
897A	2	EXP PAT ADM NCO	E-8	71G		$58,099
897A	3	PRE AD CERT NUR	GS-10	610	$42,449	
897A	4	SECY (OA)	GS-5	318	$23,533	

MANPOWER SURVEY RESULTS

897B	4	MRT (OA)	GS-5	675	$23,533	
897B	5	MRT (OA)	GS-5	675	$23,533	
897B	6	MRT (OA)	GS-5	675	$23,533	
897E	3	TNG PAT ADM NCO	E-5	71G		$36,421
897E	8	ADM DISP CLK (OA)	GS-5	303	$23,533	
897E	10	MED CLK (OA)	GS-4	679	$21,607	
897E	11	MED CLK (OA)	GS-4	679	$21,607	
897F	1	PRE-ADMIN COORD	GS-5	679	$20,989	
901A	1	CMF CHIEF	O-3	65C		$74,862
901D	1	CBT HOSP FS NCO	E-6	91M		$42,735
901E	1	COOK SUPV	WS-6	7404	$38,422	
901E	2	COOK SUPV	WS-4	7404	$34,394	
901E	2	COOK SUPV	WS-4	7404	$34,394	
901E	4	COOK	WG-6	7404	$27,632	
901E	4	COOK	WG-6	7404	$27,632	
901E	5	COOK	WG-6	7404	$27,632	
901E	5	COOK	WG-6	7404	$27,632	
901E	6	COOK	WG-4	7404	$23,687	
901F	1	FS WKR LDR	WL-2	7408	$21,914	
901F	1	FS WKR LDR	WL-2	7408	$21,914	
901F	2	FS WKR	WG-3	7408	$21,621	
901F	2	FS WKR	WG-3	7408	$21,621	
901F	2	FS WKR	WG-3	7408	$21,621	
901F	2	FS WKR	WG-3	7408	$21,621	
901F	2	FS WKR	WG-3	7408	$21,621	
901F	2	FS WKR	WG-3	7408	$21,621	
901F	2	FS WKR	WG-3	7408	$21,621	
901F	3	FS WKR	WG-3	7408	$21,621	
901F	3	FS WKR	WG-3	7408	$21,621	
901F	3	FS WKR	WG-3	7408	$21,621	
901F	3	FS WKR	WG-3	7408	$21,621	
901F	3	FS WKR	WG-3	7408	$21,621	
TOTAL	179	111 CIV, 68 MIL			$3,493,320	$3,132,211
		CIV * 105% = ADJUSTED CIV			$3,667,986	
		ADJ CIV + MIL =TOTAL PERS SAVINGS				
					$6,800,197	

APPENDIX E

MEPRS Inpatient Cost Report

OCT - SEP FY96

PART I MEDICAL EXPENSE REPORT

SECTION 1 - INPATIENT SERVICES

ACCT	DESCRIPTION	TOTAL EXPENSES	CLINIC'N SALARIES	OCCUPIED BED DAYS	COST PER OBD	TOTAL DISPS	COST PER DISP	ADMIS	COST PER ADMIS	*ALOS	*ADPL
AAAA	INT MED	4379023	199549	4494	974.42	1627	2691.47	1624	2696.44	2.8	12.3
AAAP	INT MED PARTNERSHIP	0	0	0	0.00	0	0.00	0	0.00	0.0	0.0
AAA	SUBTOTAL	4379023	199549	4494	974.42	1627	2691.47	1624	2696.44	2.8	12.3
AABP	CARDIOLOGY PARTNERSHIP	0	0	0	0.00	0	0.00	0	0.00	0.0	0.0
AAB	SUBTOTAL	0	0	0	0.00	0	0.00	0	0.00	0.0	0.0
AADA	DERM	0	0	0	0.00	0	0.00	0	0.00	0.0	0.0
AAD	SUBTOTAL	0	0	0	0.00	0	0.00	0	0.00	0.0	0.0
AAFA	GASTROENTEROLOGY	130097	9750	231	563.19	212	613.67	210	619.51	1.1	0.6
AAF	SUBTOTAL	130097	9750	231	563.19	212	613.67	210	619.51	1.1	0.6
AAJA	NEURO	6148	1436	8	768.50	5	1229.60	5	1229.60	1.6	0.0
AAJ	SUBTOTAL	6148	1436	8	768.50	5	1229.60	5	1229.60	1.6	0.0
ABAA	GEN SURG	1554647	60032	1168	1331.03	731	2126.74	720	2159.23	1.6	3.2
ABA	SUBTOTAL	1554647	60032	1168	1331.03	731	2126.74	720	2159.23	1.6	3.2
ABEA	OPHTH	175499	7158	118	1487.28	120	1462.49	119	1474.78	1.0	0.3
ABE	SUBTOTAL	175499	7158	118	1487.28	120	1462.49	119	1474.78	1.0	0.3
ABFA	ORAL SURG	74283	2814	45	1650.73	43	1727.51	43	1727.51	1.0	0.1
ABF	SUBTOTAL	74283	2814	45	1650.73	43	1727.51	43	1727.51	1.0	0.1
ABGA	ENT	43313	3022	30	1443.77	30	1443.77	30	1443.77	1.0	0.1
ABGP	INPT ENT PARTNERSHIP	227245	0	229	992.34	223	1019.04	222	1023.63	1.0	0.6
ABG	SUBTOTAL	270558	3022	259	1044.63	253	1069.40	252	1073.64	1.0	0.7
ABKA	UROL	293476	22918	215	1365.00	122	2405.54	122	2405.54	1.8	0.6
ABK	SUBTOTAL	293476	22918	215	1365.00	122	2405.54	122	2405.54	1.8	0.6
ACAA	GYN	1257949	71324	807	1558.80	421	2988.00	417	3016.66	1.9	2.2
ACAP	GYN PARTNERSHIP	0	0	0	0.00	0	0.00	0	0.00	0.0	0.0
ACA	SUBTOTAL	1257949	71324	807	1558.80	421	2988.00	417	3016.66	1.9	2.2
ACBA	OB	3396947	83027	3026	1122.59	1310	2593.09	1288	2637.38	2.3	8.3
ACBP	OB PARTNERSHIP	0	0	0	0.00	0	0.00	0	0.00	0.0	0.0
ACB	SUBTOTAL	3396947	83027	3026	1122.59	1310	2593.09	1288	2637.38	2.3	8.3

OCT - SEP FY96

PART I MEDICAL EXPENSE REPORT

SECTION 1 - INPATIENT SERVICES

ACCT	DESCRIPTION	TOTAL EXPENSES	CLINIC'N SALARIES	OCCUPIED BED DAYS	COST PER OBD	TOTAL DISPS	COST PER DISP	ADMIS	COST PER ADMIS	*ALOS	*ADPL
ADAA	PEDS	456861	77780	439	1040.69	208	2196.45	200	2284.31	2.1	1.2
ADA	SUBTOTAL	456861	77780	439	1040.69	208	2196.45	200	2284.31	2.1	1.2
ADBA	NSY	997015	24140	1971	505.84	968	1029.97	955	1043.99	2.0	5.4
ADB	SUBTOTAL	997015	24140	1971	505.84	968	1029.97	955	1043.99	2.0	5.4
AEAA	ORTHO	1847982	99084	1169	1580.82	683	2705.68	685	2697.78	1.7	3.2
AEA	SUBTOTAL	1847982	99084	1169	1580.82	683	2705.68	685	2697.78	1.7	3.2
AEBA	PODIATRY	0	0	0	0.00	0	0.00	0	0.00	0.0	0.0
AEBP	PODIATRY PARTNERSHIP	166484	0	112	1486.46	102	1632.20	103	1616.35	1.1	0.3
AEB	SUBTOTAL	166484	0	112	1486.46	102	1632.20	103	1616.35	1.1	0.3
AGAA	INT MED FP	242466	110426	175	1385.52	55	4408.47	51	4754.24	3.2	0.5
AGA	SUBTOTAL	242466	110426	175	1385.52	55	4408.47	51	4754.24	3.2	0.5
AGBA	FAMILY PRACTICE SURGER	407	2060	0	0.00	0	0.00	0	0.00	0.0	0.0
AGB	SUBTOTAL	407	2060	0	0.00	0	0.00	0	0.00	0.0	0.0
AGCA	OB FP	89695	13663	75	1195.93	35	2562.71	37	2424.19	2.1	0.2
AGC	SUBTOTAL	89695	13663	75	1195.93	35	2562.71	37	2424.19	2.1	0.2
AGDA	PEDS FP	2742	302	0	0.00	0	0.00	0	0.00	0.0	0.0
AGD	SUBTOTAL	2742	302	0	0.00	0	0.00	0	0.00	0.0	0.0
AGEA	GYN FP	1894	426	0	0.00	0	0.00	0	0.00	0.0	0.0
AGE	SUBTOTAL	1894	426	0	0.00	0	0.00	0	0.00	0.0	0.0
AGGA	ORTHO FP	763	540	0	0.00	0	0.00	0	0.00	0.0	0.0
AGG	SUBTOTAL	763	540	0	0.00	0	0.00	0	0.00	0.0	0.0
AGHA	NURSERY F.P.	56804	4429	109	521.14	58	979.38	52	1092.38	1.9	0.3
AGH	SUBTOTAL	56804	4429	109	521.14	58	979.38	52	1092.38	1.9	0.3
	TOTAL	15401740	793880	14421	1068.01	6953	2215.12	6883	2237.65	2.1	39.5

OCT - SEP FY96 PART I MEDICAL EXPENSE REPORT

SECTION 1 - INPATIENT SERVICES

ACCT	DESCRIPTION	TOTAL EXPENSES	CLINIC'N SALARIES	OCCUPIED BED DAYS	COST PER OBD	TOTAL DISPS	COST PER DISP	ADMIS	COST PER ADMIS	*ALOS	*ADPL

*ALOS=OBD/DISPOSITIONS *ADPL=OBD/NUMBER OF DAYS IN PERIOD

APPENDIX F

Cost Formulae

Cost formulae listed below were originally used by Rogers' study that compared Wilford Hall Medical Center's MEPRS cost to CHAMPUS costs for the same level of services.

FORMULA 1.
Calculation formula for inpatient professional services if provided by the civilian sector and paid for by CHAMPUS:

Step 1.

$$\frac{\text{Total Government Hospital Costs}}{\text{Total Government Professional Costs}} = \text{Estimated CHAMPUS Professional Fee Multiplier}$$

$$\frac{\$2,119,891}{\$6,284,150} = .3373$$

Step 2.

$$\text{Total Hospital CHAMPUS Charge for DACH} \times \text{Estimated Professional Fee Multiplier} = \text{Estimated CHAMPUS Professional Fees}$$

$$\$20,348,945 \times .3373 = \$6,864,500$$

FORMULA 2.
Calculation formula for patient cost-share if inpatient services were provided by the civilian sector and paid for by CHAMPUS:

Step 1.

$$\frac{\text{Total Patient Cost-Share}}{\text{Total number of Admissions}} = \text{Average Cost-Share per Admission}$$

$$\frac{\$1,961,641}{1,309} = \$1,499$$

Cost Formulas

Step 2.

Average Cost-Share per Admission Estimated X Number of DACH Inpatient Admissions	=	Total Estimated Patient Cost-Share

$1,499 X 6,746 = $10,112,254

FORMULA 3.
Calculation formula for DACH's inpatient workload if these were provided by the civilian sector and paid for by CHAMPUS:

Total Allowable CHAMPUS Charge + CHAMPUS Professional Fees - Patient Cost-Share	=	Total Cost to Buy DACH's Inpatient Services

$20,348,945
+$6,864,500
-$10,112,254
$17,101,191

FORMULA 4. Calculation formula for DACH's direct inpatient MEPRS fixed costs:

Total MEPRS Inpatient Expense - Inpatient Salary Savings* - Other MEPRS Savings	=	DACH's MEPRS Fixed Costs

$15,401,739
-$6,800,197
-$3,039,941
$5,561,601

*Inpatient salary savings based on MEDCOM Manpower Assessment Survey Model.

APPENDIX F (continued)

Cost Formulas

FORMULA 5.
Calculation formula for DACH's revised Federal appropriation for the provision of inpatient services:

Total MEPRS Inpatient Expense		DACH's Revised
- Direct inpatient costs(Result of Formula 4)	=	Funding Level

$15,401,739
+$5,561,601
$9,840,138

FINAL EVALUATION OF COSTS FOR "MAKE" OR "BUY" DECISION:
Examine the result of Formula 5 (DACH's costs) and compare and it to the result of Formula 3 (CHAMPUS costs)--the lower of these results is the least costly method of providing inpatient services for DACH's inpatient workload.

Result of Formula 5: $9,840,138

Result of Formula 3: $17,101,191

After examining the results above, it is concluded that DACH provides inpatient services at a much lower cost to the government than civilian providers would reimbursed at the CHAMPUS prevailing rate.

APPENDIX G

MEPRS Inpatient Cost Savings

MEPRS COST SAVINGS

Linen Laundry Contract	$53,907
Linen Replacement Cost	$10,828
Inpatient Ward Housekeeping Cost	$56,909
Inpatient Indirect Supply Cost	$2,202,204
Food Service Indirect Supply Cost	$40,000
CRNA Contract	$617,200
Food Service Indirect Equipment Cost	$58,893
Total Inpatient MEPRS Cost Savings	$3,039,941

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